

<i>SERFF Tracking Number:</i>	<i>UHLC-125942058</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>United HealthCare Insurance Company</i>	<i>State Tracking Number:</i>	<i>41087</i>
<i>Company Tracking Number:</i>	<i>LTC POL 1000 AR</i>		
<i>TOI:</i>	<i>LTC03I Individual Long Term Care</i>	<i>Sub-TOI:</i>	<i>LTC03I.001 Qualified</i>
<i>Product Name:</i>	<i>INDIVIDUAL LONG TERM CARE</i>		
<i>Project Name/Number:</i>	<i>LTC/LTC POL 1000 AR</i>		

Filing at a Glance

Company: United HealthCare Insurance Company

Product Name: INDIVIDUAL LONG TERM CARE SERFF Tr Num: UHLC-125942058 State: ArkansasLH

TOI: LTC03I Individual Long Term Care

SERFF Status: Closed

State Tr Num: 41087

Sub-TOI: LTC03I.001 Qualified

Co Tr Num: LTC POL 1000 AR

State Status: Approved-Closed

Filing Type: Form/Rate

Co Status:

Reviewer(s): Marie Bennett

Authors: Wanda Augustus, Gerry McCadden, Karyn Feeney

Disposition Date: 02/19/2009

Date Submitted: 12/12/2008

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: LTC

Status of Filing in Domicile: Pending

Project Number: LTC POL 1000 AR

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 02/19/2009

Explanation for Other Group Market Type:

State Status Changed: 02/19/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

December 12, 2008

Attn: Long Term Care Insurance Analyst

Arkansas Insurance Department

Life & Health

SERFF Tracking Number: UHLC-125942058 *State:* Arkansas
Filing Company: United HealthCare Insurance Company *State Tracking Number:* 41087
Company Tracking Number: LTC POL 1000 AR
TOI: LTC03I Individual Long Term Care *Sub-TOI:* LTC03I.001 Qualified
Product Name: INDIVIDUAL LONG TERM CARE
Project Name/Number: LTC/LTC POL 1000 AR

1200 West Third Street
Little Rock, Arkansas 72201

RE: United HealthCare Insurance Company ("United")
Individual Long Term Care Insurance Policy Form -- LTC POL 1000 AR et al.
(see attached listing of new forms)
United NAIC No. 79413
United FEIN No. 36-2739571

Dear LTC Insurance Analyst:

We enclose for filing, copies of United's individual tax-qualified comprehensive long-term care insurance policy, Nonforfeiture Benefit rider, and associated forms, actuarial memorandum and rates. The enclosed policy is a guaranteed renewable long term care insurance policy intended to meet the Partnership requirements. The forms that are included with this filing are listed on an attached page.

The forms are new and will not replace any form currently on file with your Department. The policy will be sold either through brokers, direct telephone sales or Direct Mail.

Coverage under the policy consists of Nursing Home, Assisted Living Facility, Hospice Facility, Bed Reservation, Home Health Care, Adult Day Care and Respite Care Benefits. Benefits are payable for the charges incurred, up to a chosen maximum daily benefit. Limited expenses are also payable for Caregiver Training and Home Modification.

Benefits are subject to a Lifetime Waiting Period (90 days Facility benefits; 0 days Home and Community Care benefits) and a lifetime maximum benefit (24 months, 36 months or 48 months). The lifetime maximum benefit is based on a "pool of money" approach.

An automatic inflation increase is built in the base policy which increases benefits at a rate of 5% compounded annually. Increases occur annually on the policy anniversary for as long as the policy remains in force.

An optional Nonforfeiture Benefit Rider is available that provides a reduced paid-up benefit amount if the policy lapses for non-payment of premium after the rider has been in force for three years.

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<i>Project Name/Number:</i>	<i>LTC/LTC POL 1000 AR</i>		

The forms have been filed in the Company's domicile state of Connecticut and are currently pending.

We respectfully request your favorable consideration and approval of this filing. Should you have any questions or comments that you feel could best be handled by contacting me, please feel free to do so via telephone (267) 470-1537 or email karyn_a_feeney@uhc.com.

Sincerely,

Karyn A. Feeney
 Director, Contract & Compliance
 e-mail: karyn_a_feeney@uhc.com
 phone: (267) 470-1537
 fax: (267) 470-1908

LISTING OF NEW FORMS

Form Form Number

Policy	LTC POL 1000 AR
Outline of Coverage	LTC OC 1000
Nonforfeiture Benefit Rider	LTC NFB 1000
Application	LTC APP 1000
Application	LTC APPSU 1000
Health Questionnaire	LTC HQ 1000
Receipt	LTC REC 1000
Replacement Notice	LTC RN 1000
Potential Rate Increase Disclosure Form	LTC PRI 1000
Personal Worksheet	LTC PWS 1000

SERFF Tracking Number:	UHLC-125942058	State:	Arkansas
Filing Company:	United HealthCare Insurance Company	State Tracking Number:	41087
Company Tracking Number:	LTC POL 1000 AR		
TOI:	LTC03I Individual Long Term Care	Sub-TOI:	LTC03I.001 Qualified
Product Name:	INDIVIDUAL LONG TERM CARE		
Project Name/Number:	LTC/LTC POL 1000 AR		

Thing You Should Know Disclosure LTC TYSK 1000

Notice LTC NOTICE AR

Policy Disclosure Form LTC PDF 1000 AR

Solicitation Disclosure Form LTC PSF 1000 AR

Company and Contact

Filing Contact Information

Karyn A. Feeney, Director, Contract and Compliance	Karyn_A_Feeney@uhc.com
601 Office Center Drive	(267) 470-1537 [Phone]
Ft. Washington, PA 19034	(267) 470-1906[FAX]

Filing Company Information

United HealthCare Insurance Company	CoCode: 79413	State of Domicile: Connecticut
450 Columbus Boulevard	Group Code: 707	Company Type: Life and Health
PO Box 150450		
Hartford, CT 06115-0450	Group Name:	State ID Number:
(215) 653-8046 ext. [Phone]	FEIN Number: 36-2739571	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$750.00
Retaliatory?	No
Fee Explanation:	14 FORMS AND 1 RATE = \$750.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United HealthCare Insurance Company	\$750.00	12/12/2008	24510297

SERFF Tracking Number:	UHLC-125942058	State:	Arkansas
Filing Company:	United HealthCare Insurance Company	State Tracking Number:	41087
Company Tracking Number:	LTC POL 1000 AR		
TOI:	LTC03I Individual Long Term Care	Sub-TOI:	LTC03I.001 Qualified
Product Name:	INDIVIDUAL LONG TERM CARE		
Project Name/Number:	LTC/LTC POL 1000 AR		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Marie Bennett	02/19/2009	02/19/2009

<i>SERFF Tracking Number:</i>	<i>UHLC-125942058</i>	<i>State:</i>	<i>Arkansas</i>
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<i>TOI:</i>	<i>LTC03I Individual Long Term Care</i>	<i>Sub-TOI:</i>	<i>LTC03I.001 Qualified</i>
<i>Product Name:</i>	<i>INDIVIDUAL LONG TERM CARE</i>		
<i>Project Name/Number:</i>	<i>LTC/LTC POL 1000 AR</i>		

Disposition

Disposition Date: 02/19/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: UHLC-125942058 State: Arkansas

Filing Company: United HealthCare Insurance Company State Tracking Number: 41087

Company Tracking Number: LTC POL 1000 AR

TOI: LTC031 Individual Long Term Care Sub-TOI: LTC031.001 Qualified

Product Name: INDIVIDUAL LONG TERM CARE

Project Name/Number: LTC/LTC POL 1000 AR

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		Yes
Supporting Document	PARTNERSHIP CERTIFICATION		Yes
Form	POLICY		Yes
Form	OUTLINE OF COVERAGE		Yes
Form	RIDER		Yes
Form	APPLICATION		Yes
Form	APPLICATION		Yes
Form	APPLICATION		Yes
Form	APPLICATION		Yes
Form	APPLICATION		Yes
Form	POTENTIAL RATE INCREASE		Yes
	DISCLOSURE		
Form	PERSONAL WORKSHEET		Yes
Form	THINGS YOU SHOULD KNOW		Yes
Form	CONSUMER NOTICE		Yes
Form	POLICY DISCLOSURE FORM		Yes
Form	SOLICITATION DISCLOSURE FORM		Yes
Rate	Actuarial Memorandum		No

SERFF Tracking Number:	UHLC-125942058	State:	Arkansas
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TOI:	LTC03I Individual Long Term Care	Sub-TOI:	LTC03I.001 Qualified
Product Name:	INDIVIDUAL LONG TERM CARE		
Project Name/Number:	LTC/LTC POL 1000 AR		

Form Schedule

Lead Form Number: LTC POL 1000 AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LTC POL 1000 AR	Policy/Cont	POLICY ract/Fratern al Certificate	Initial			LTC POL 1000 AR.pdf
	LTC OC 1000	Outline of	OUTLINE OF Coverage COVERAGE	Initial			LTC OC 1000.pdf
	LTC NFB 1000	Policy/Cont	RIDER ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			LTC NFB 1000.pdf
	LTC APP 1000	Application/	APPLICATION Enrollment Form	Initial			LTC APP 1000.pdf
	LTC APPSU 1000	Application/	APPLICATION Enrollment Form	Initial			LTC APPSU 1000.pdf
	LTC HQ 1000	Application/	APPLICATION Enrollment Form	Initial			LTC HQ 1000.pdf
	LTC REC 1000	Application/	APPLICATION Enrollment Form	Initial			LTC REC 1000.pdf
	LTC RN 1000	Application/	APPLICATION Enrollment Form	Initial			LTC RN 1000.pdf
	LTC PRI 1000	Other	POTENTIAL RATE INCREASE	Initial			LTC PRI 1000.pdf

SERFF Tracking Number:	UHLC-125942058	State:	Arkansas
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Company Tracking Number:	LTC POL 1000 AR		
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Product Name:	INDIVIDUAL LONG TERM CARE		
Project Name/Number:	LTC/LTC POL 1000 AR		

DISCLOSURE

LTC PWS 1000	Other	PERSONAL WORKSHEET	Initial	LTC PWS 1000.pdf
LTC TYSK 1000	Other	THINGS YOU SHOULD KNOW	Initial	LTC TYSK 1000.pdf
LTC NOTICE AR	Other	CONSUMER NOTICE	Initial	LTC NOTICE AR.pdf
LTC PDF 1000 AR	Other	POLICY DISCLOSURE FORM	Initial	LTC PDF 1000 AR.pdf
LTC PSF 1000 AR	Other	SOLICITATION DISCLOSURE FORM	Initial	LTC PSF 1000 AR.pdf

United HealthCare Insurance Company
Home Office: [450 Columbus Boulevard, Hartford, CT 06115]

Administrative Office: [P.O. Box 541203, Waltham, MA 02453-1203, 877-272-3959]

Tax Qualified Long-Term Care Insurance Policy

THIS POLICY IS INTENDED TO BE A QUALIFIED LONG-TERM CARE INSURANCE CONTRACT UNDER THE FEDERAL TAX CODE AS DEFINED UNDER SECTION 7702B(b) OF THE INTERNAL REVENUE CODE, AS AMENDED.

United HealthCare Insurance Company (UHC) will provide the benefits described in this Policy to the insured Policyholder (referred to as You, Your, and Yours) in acceptance of the application and premium, and subject to all Policy provisions.

In this Policy, "We", "Our", and "Us" are used to refer to United HealthCare Insurance Company.

The Policy becomes effective at 12:00 a.m. Standard Time on the "Effective Date" shown on the "Policy Information Page."

Right To Renew. This Policy is Guaranteed Renewable. This means You have the right, subject to the terms of the Policy, to continue this Policy as long as You pay Your premiums on time.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from UHC.

Notice To Buyer. This Policy may not cover all of the costs associated with long-term care, which may be incurred by You during the period of coverage. You are advised to periodically review this Policy in relation to the changes in the cost of long-term care. This Policy is subject to certain coverage limitations and exclusions. You are advised to carefully review all limitations and exclusions.


CAUTION. This Policy was issued based on Your answers to the questions on Your application and payment of the first premium. A copy of Your application is attached. If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If for any reason, any of Your answers are incorrect, please contact Us at [P.O. Box 541203, Waltham, MA 02453-1203].

Thirty Day Right To Examine Policy. If You are not satisfied for any reason, You may return Your Policy within thirty (30) days after receipt. The premium will be refunded, less any claims paid during this period. When so returned, the Policy is void from the beginning. Return the Policy to Us at [Administrative Office: P.O. Box 541203, Waltham, MA 02453-1203].

The Policy is delivered in and governed by the laws of the State of Arkansas.

Please Read Your Insurance Policy Carefully. It is a legal contract between You and Us.

Signed for United HealthCare Insurance Company


President

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POLICY INFORMATION PAGE

POLICYHOLDER:	[John Doe]
POLICY NUMBER:	[UHCXXX]
PLAN NAME:	[Care at Home Plus]
ORIGINAL EFFECTIVE DATE:	[January 1, 2008]
POLICY ANNIVERSARY:	[January 1, 2008]
PREMIUM MODE:	[Monthly][Quarterly][Semiannual][Annual]
LIFETIME LEVEL MODAL PREMIUM*:	[\$XXXX.XX]
AUTOMATIC INFLATION INCREASES:	Yes
NONFORFEITURE BENEFIT RIDER	[Yes] [No]

Schedule of Benefits

Lifetime Waiting Period	<div>Facility Benefits 90 days</div> <div>Home and Community Benefits [0 days]</div>
Benefit Period	[XX-XXX] days
Maximum Lifetime Benefit	[\$XX,XXX]
Maximum Daily Benefit <div>Facility Benefits <i>Nursing Home</i> <i>Assisted Living Facility</i> </div> <div>Home and Community Benefits <i>Home Health Care Services</i> <i>Adult Day Care</i> <i>Homemaker Services</i> <i>Hospice Care</i> </div>	<div>[\$XX-\$XXX] per day</div> <div>[\$XX-\$XXX] per day</div>
Additional Benefits <div>Caregiver Training Benefit</div> <div>Home Modification Benefit</div> <div>Respite Care Benefit</div> <div>Bed Reservation</div>	<div>[\$500] Lifetime Benefit</div> <div>[\$1,500] Lifetime Benefit</div> <div>[21] days per Calendar Year</div> <div>[21] days per Calendar Year</div>

*An additional cost has been included if You pay premiums more frequently than annually.

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Section I

Definitions

When used in this Policy the following words and phrases have the meaning given.

Activities of Daily Living include the following functions and are used as one measure to determine Your eligibility for benefits:

- (a) Bathing: washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower;
- (b) Continence: ability to maintain control of bowel and bladder function or, when not able to maintain control of bowel or bladder function, the ability to perform related personal hygiene (including caring for catheter or colostomy bag);
- (c) Dressing: putting on and taking off all items of clothing and any required braces, fasteners, or artificial limbs;
- (d) Eating: feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously;
- (e) Toileting: getting to and from the toilet, getting on and off the toilet, and performing related personal hygiene;
- (f) Transferring: moving into or out of a bed, chair or wheelchair.

Adult Day Care means a program of social and health-related services for six (6) or more individuals, which is provided during the day in an Adult Day Care Center for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the Home. It does not include twenty-four (24) hour care. It does not include care provided by a family member related by blood or marriage.

Adult Day Care Center means a place that is licensed to provide Adult Day Care in accordance with state laws in which preventive, remedial, and restorative services are provided in a protective environment for part of the twenty-four (24) hour day. If licensing is not required, Adult Day Care Center means a place that:

1. provides Adult Day Care; and
2. maintains a daily written record of each client who receives services; and
3. has a staff including, at least, a director, one full-time registered professional Nurse, licensed vocational Nurse or licensed practical Nurse, and enough full-time staff to maintain no more than an eight (8) to one (1) client-staff ratio; and
4. has established procedures for obtaining appropriate aid in the event of a medical emergency.

Assisted Living Facility means an institution that is licensed by the appropriate federal or state agency to engage primarily in providing care and unscheduled services to at least six (6) resident inpatients in one location and meets all of the following criteria:

1. provides twenty-four (24) hour-a-day care and services sufficient to support the needs of a Chronically Ill individual; and
2. has a trained and ready to respond employee on duty at all times to provide that care and service; and
3. provides three (3) meals a day and accommodates special dietary needs; and
4. has arrangements with a Physician or Nurse to furnish medical care in the case of an emergency; and
5. has the appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.

If an institution (such as a congregate care facility or life care community) has multiple licenses or multiple purposes, only the portion, ward, wing or unit (including a separate room or apartment) that specifically provides the above described care and meets all of the above requirements will qualify as an Assisted Living Facility.

Calendar Year means the period of time from January 1st through December 31st.

Care Advisor means the person appointed by Us who, either alone or as part of a team, is responsible for performing assessments and reassessments, developing Plans of Care, coordinating the provision of care, and monitoring the delivery of services to suit Your specific care needs. Care Advisors are familiar with the Care Providers available in the area. Care Advisors will help identify qualified caregivers that are acceptable to You and Your family. In all cases, You are responsible for choosing the actual Care Providers to be used. If for any reason You are not satisfied with a Care Provider, You may request that the Care Advisor identify other Providers from which to choose.

Caregiver Training means expenses You incur for training an unpaid caregiver to care for You in Your Home. The person receiving the training can be a relative or someone else chosen by You, but in no event will We pay for training provided to someone who will be paid to care for You. The training cannot be received while You are confined in a Hospital, Nursing Facility or Residential Care Facility, unless it is reasonably expected that the training will make it possible for You to go Home where You can be cared for by the person receiving the training.

Care Provider means a Home Health Aide, Homemaker, or Nurse provided through a licensed Home Health Care Agency or referred by a licensed referral agency or licensed nurses' registry.

Chronically Ill means that within the preceding twelve (12) months, You have been certified by a Licensed Health Care Practitioner as:

1. being unable to perform without Substantial Assistance from another individual two (2) or more of the Activities of Daily Living for a period expected to last at least ninety (90) days due to a loss of functional capacity; or
2. requiring Substantial Supervision to protect You from threats to health and safety due to Severe Cognitive Impairment.

Written certification must be renewed or updated at least every twelve (12) months.

Class means a population segment with the same or similar Policy characteristics such as issue year, zip code, issue age, underwriting and rating classification, selected benefit options, or Lifetime Waiting Period.

Custodial Care means services provided on an extended basis to a Chronically Ill individual that are intended to maintain a person's health and/or functional status. Custodial Care does not include any transportation or other service which is chiefly for personal convenience or companionship.

Family Member means Your spouse and anyone who is related to You or Your spouse (including adopted, in-law and step-relatives) such as a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece.

Home means any place where You reside. Home is not a Skilled Nursing Facility, Assisted Living Facility, Alzheimer's facility, Hospice facility, or Hospital.

Home Health Aide means a person whose main function is to provide personal care services. If state and local licensing or certification is required, the person must be licensed or certified as a Home Health Aide where the service is performed.

Home Health Care means medical and non-medical services provided to ill, disabled or infirm persons in their Home. These services may include Homemaker care, assistance with Activities of Daily Living, and Respite Care services. These services must be provided by a Care Provider through a licensed Home Health Care Agency or referred by a licensed referral agency or licensed nurses' registry.

Home Health Care Agency means an organization licensed or certified as a Home Health Care Agency under the laws where it is located, under a public health law or similar law, if licensing or certification is required, to provide Home Health Care services.

Homemaker means a skilled or unskilled person who performs maintenance services that are necessary for or consistent with Your ability to stay in Your Home. These activities may include, but are not limited to, preparing meals, laundry, and light housekeeping.

Hospice means a facility, unit of a facility, public or private agency or unit of a public or private agency that meets federal certification requirements as a Hospice, or is comparably licensed under the laws where it is located, to provide care or management to individuals that are Terminally Ill.

Hospital means an acute care facility defined and operated pursuant to state laws.

Licensed Health Care Practitioner means any Physician (as defined in section 1861(r)(1) of the Social Security Act), any registered professional Nurse, any Licensed Social Worker or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

Lifetime Waiting Period means the number of days after the Policy Effective Date during which You are both: (1) Chronically Ill; and (2) receiving paid Qualified Long-Term Care services before You can receive benefits. These days need not be consecutive. The Lifetime Waiting Period for this Policy is shown in the Schedule Page. Benefits will not be paid for services You receive during the Lifetime Waiting Period. The Lifetime Waiting Period must be satisfied only once during the life of Your Policy.

Maximum Daily Benefit means the greatest amount that We will pay for all expenses combined that You incur on any one day under all benefits available under this Policy. An expense is considered to be incurred on the day on which the care or service is received.

Maximum Lifetime Benefit means the amount that results by multiplying the Maximum Daily Benefit by the number of Benefit Period days that has been elected by the Policyholder.

Medicare means the Health Insurance for Aged Act, Title XVIII of the Social Security Act Amendments of 1965, as Constituted and Later Amended.

Mental or Nervous Disorder means a condition of neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

Nurse means Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.).

Nursing Care means services requiring the professional skills of a Nurse under the orders of a Physician that improve or maintain Your health.

Physician means a Physician as defined in section 1861(r)(1) of the Social Security Act, as amended. It is a licensed doctor practicing within the scope of his/her license and rendering care and treatment that is appropriate for Your condition and locality. The term does not include Your spouse or Your immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), or a person living in Your household.

Plan of Care means a written description of Your needs by a Licensed Health Care Practitioner that fairly, accurately and appropriately addresses Your need for Qualified Long-Term Care services . The Plan of Care must specify the type, frequency (including duration), and type of Care Providers required by You.

Policy means this legal contract, including the application and any riders or endorsements issued to the Policyholder providing the benefits described herein.

Qualified Long-Term Care means services for necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and Maintenance or Personal Care services which are required by a Chronically Ill individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Respite Care means Nursing Care, Custodial Care or Hospice Care provided to You in Your Home or facility that allows family or volunteer caregivers temporary relief.

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that: (a) is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and (b) is measured by clinical evidence and standardized tests that reliably measure impairment in the person's (i) short-term or long-term memory; (ii) orientation as to people, places or time; and (iii) deductive or abstract reasoning.

Skilled Nursing Facility means the same term as defined by Medicare.

Skilled Nursing Services mean services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

Substantial Assistance means the support of another person who must provide physical hands-on assistance or who must be within arm's reach of You to prevent, by physical intervention if necessary, injury while You perform an Activity of Daily Living.

Substantial Supervision means continual supervision which may include cuing by verbal prompting, gestures, or other demonstrations by another person that is necessary to protect You from harming Yourself or others when You have a Severe Cognitive Impairment.

Terminally Ill means an illness or injury, as certified by a Physician that results in a person's death within six (6) months of the diagnosis.

Section II

Eligibility

Benefit Eligibility

To be eligible for benefits provided by this Policy, You must be certified as Chronically Ill pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Chronically Ill means that within the preceding twelve (12) months, You have been certified by a Licensed Health Care Practitioner as:

1. being unable to perform without Substantial Assistance from another individual two (2) or more of the Activities of Daily Living for a period expected to last at least ninety (90) days due to a loss of functional capacity; or
2. requiring Substantial Supervision to protect You from threats to health and safety due to Severe Cognitive Impairment.

Written certification must be renewed or updated at least every twelve (12) months.

Eligibility for the Payment of Benefits

Benefits are payable only for Qualified Long-Term Care Services. All benefits are subject to Your Maximum Lifetime Benefit. Certain benefits are subject to Your Maximum Daily Benefit and Lifetime Waiting Period.

Section III

Benefits

Facility Benefits

We will pay one-hundred percent (100%) of the expenses You incur for Skilled Nursing Services rendered in a Skilled Nursing Facility, Assisted Living Facility or Hospice facility up to Your Maximum Daily Benefit and Maximum Lifetime Benefit subject to Your Lifetime Waiting Period.

Home and Community Benefits

We will pay one-hundred percent (100%) of the expenses You incur for Skilled Nursing Services, Home Health Care Services, Adult Day Care, Homemaker Services or Hospice Care rendered in Your Home or other community-based setting up to Your Maximum Daily Benefit and Maximum Lifetime Benefit.

The Lifetime Waiting Period for Home and Community Benefits is shown on the Schedule Page. Days for which Home and Community Benefits are paid will count toward satisfying the Lifetime Waiting Period for Facility Benefits.

Alternative Plan of Care Benefit

We may pay for alternative benefits under this provision for Qualified Long-Term Care Services that are medically acceptable, cost effective and agreed to by You, Us and Your Physician up to Your Maximum Daily Benefit and Your Maximum Lifetime Benefit.

You maintain the right to discontinue the Alternative Plan of Care Benefit and resume receiving benefits as defined in this Policy.

Bed Reservation Benefit

We will pay one-hundred percent (100%) of the expenses You incur to reserve Your bed, if You are hospitalized temporarily while receiving eligible services in a facility covered under this Policy and that facility charges You a fee to reserve Your bed, for up to [twenty-one (21)] days per Calendar Year subject to Your Maximum Daily Benefit and Maximum Lifetime Benefit.

Caregiver Training Benefit

We will pay one-hundred percent (100%) of the expenses You incur for Caregiver Training received by an informal (unpaid) caregiver for up to the Caregiver Training Lifetime Benefit as shown on the Schedule Page. This benefit is not subject to Your Maximum Daily Benefit, but it is subject to Your Maximum Lifetime Benefit.

There is no Lifetime Waiting Period for the Caregiver Training Benefit. Days for which the Caregiver Training Benefit is paid will not count toward satisfying the Lifetime Waiting Period.

Home Modification Benefit

We will pay one-hundred percent (100%) of the expenses You incur for: (a) structural modification to Your Home that will allow You to remain in Your Home; or (b) medical equipment designed and used to treat a sickness or injury for up to the Home Modification Lifetime Benefit as shown on the Schedule Page. This benefit is not subject to Your Maximum Daily Benefit, but it is subject to Your Maximum Lifetime Benefit.

There is no Lifetime Waiting Period for the Home Modification Benefit. Days for which the Home Modification Benefit is paid will not count toward satisfying the Lifetime Waiting Period.

Respite Care Benefit

We will pay one-hundred percent (100%) of the expenses You incur for each day You receive Respite Care provided at Home or in an approved facility for up to [twenty-one (21)] days per Calendar Year up to Your Maximum Daily Benefit and Your Maximum Lifetime Benefit.

There is no Lifetime Waiting Period for the Respite Care Benefit. Days for which the Respite Care Benefit is paid will not count toward satisfying the Lifetime Waiting Period.

Automatic Inflation Increases

As protection against inflation, the Maximum Daily Benefit amount will be increased by five percent (5%) compounded annually on each Policy Anniversary date. Any time Your Maximum Daily Benefit amount changes under this section, the Maximum Lifetime Benefit will be increased by five percent (5%) of the Remaining Lifetime Benefit. The Remaining Lifetime Benefit on the current Policy Anniversary is the Maximum Lifetime Benefit on the previous Policy Anniversary less the total of all claims paid up to the current Policy Anniversary.

Inflation increases are made without regard to Your age, claim status, claim history or the length of time Your Policy has been in force. Your Premium will not increase for each increase in benefits under this section.

Contingent Benefit Upon Lapse

The Contingent Benefit upon Lapse shall be triggered if We increase the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of Your initial annual premium as set forth in the table below, and the Policy lapses within one-hundred twenty (120) days of the due date of the premium so increased. We will notify You at least forty-five (45) days prior to the due date of the premium reflecting the rate increase.

On or before the effective date of a substantial premium increase as defined above, You have the option to:

1. Reduce Policy benefits provided by Your current coverage without additional underwriting so that required premium payments are not increased; or
2. Convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms described below. This option may be elected at any time during the one-hundred twenty (120) day period referenced above.

If there is a default or lapse in coverage at any time during the one-hundred twenty (120) day period referenced above, You shall be considered to have chosen the offer to convert in paragraph number two (2) above.

A shortened benefit period provides paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but no increases thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits will be subject to the following limits:

1. one-hundred percent (100%) of the sum of all premiums paid for this Policy, including the premiums paid prior to any changes in benefits; or
2. thirty (30) times the Maximum Daily Benefit Amount in effect at the time of lapse.

However, the total benefits payable under the Policy for a period of care, including this Contingent Benefit upon Lapse, will not exceed the Maximum Policy Benefit listed in the Schedule.

Triggers for Contingent Benefit Upon Lapse

<u>Issue Age</u>	<u>Substantial Percent Over Initial Premium</u>	<u>Issue Age</u>	<u>Substantial Percent Over Initial Premium</u>	<u>Issue Age</u>	<u>Substantial Percent Over Initial Premium</u>
29 and under	200%	66	48%	79	22%
30-34	190%	67	46%	80	20%
35-39	170%	68	44%	81	19%
40-44	150%	69	42%	82	18%
45-49	130%	70	40%	83	17%
50-54	110%	71	38%	84	16%
55-59	90%	72	36%	85	15%
60	70%	73	34%	86	14%
61	66%	74	32%	87	13%
62	62%	75	30%	88	12%
63	58%	76	28%	89	11%
64	54%	77	26%	90 and over	10%
65	50%	78	24%		

Section IV

Exclusions and Limitations

We will not pay benefits for any care services that are:

1. Services for which benefits are payable under Medicare or other governmental program, except Medicaid; any state or federal workers' compensation, employer's liability or occupational disease law; a motor vehicle no-fault law;
2. Mental or Nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;
3. Treatment provided in a government facility, unless a charge is made and You are legally obligated to pay;
4. Services provided by family members unless: (a) he or she is a regular employee of a Home Health Care Agency; (b) the Home Health Care Agency receives payment for the services; and (c) he or she receives no compensation other than the normal compensation for employees of that Home Health Care Agency;
5. Illness or medical condition arising out of war or any act of war, declared or undeclared while serving in the military service or any auxiliary unit attached thereto;

6. Services for attempted suicide or intentionally self-inflicted injury;
7. Services received outside the United States and its possessions;
8. Services and supplies not in the Plan of Care;
9. Alcoholism, drug addiction, or chemical dependency unless as a result of medication as prescribed by a Physician; and
10. Services for which no charge is normally made in the absence of insurance.

Section V

Premium Provisions

Premiums

We provide insurance coverage in return for premium payment. The first premium is due on the Effective Date. Future premiums are due on or before each Premium Due Date in order for insurance to remain in effect.

Premium Changes. This Policy is guaranteed renewable. We will not change Your premiums because of age or health. We may, however, change Your premiums on a class basis, subject to applicable state insurance department approval, but only if We change the premiums for all Policyholders in the same class.

If We elect to change premium rates, Your premium will change on the first Premium Due Date following:

1. The effective date of the change stated in Our written notice to You; or
2. The date any of the Policy's terms are changed, including changes due to any federal or state law or regulation affecting Our liability under the Policy.

We will notify You of any premium change at least [forty-five (45)] days before the Premium Due Date on which Your premiums change.

Refund of Unearned Premium. We will make a pro-rata refund of premium paid for the period beyond the date of cancellation or death of the Policyholder. We will pay the refund directly to You or Your estate.

Grace Period. You have a thirty-one (31) day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. It will terminate at the end of the grace period if all premiums due are not paid, unless non-payment is due to a clerical error made by You or by Us.

Unintentional Lapse. In addition to Yourself, You have a right to designate another individual to receive notification of lapse or termination. If the premium is not paid by the end of the grace period, We will inform both You and, if chosen, the designated individual at least thirty-one (31) days before the effective date of lapse. The notice will be given by first class United States mail, postage

prepaid, to You and to the designated individual. Notice is considered to have been given as of five (5) days after the date of mailing.

Right to Reduce Coverage and Lower Premiums. You may reduce the Policy's benefits and correspondingly, the premium required to keep this Policy in force, by:

1. Reducing the Maximum Daily Benefit; or
2. Reducing the Maximum Lifetime Benefit, (provided You do not already have the minimum amount available in force).

You may make any of these changes without submitting any evidence of insurability. To make such a change, You must submit a written request to Our Customer Service Department at [United HealthCare Insurance Company, LTC Administration, P.O. Box 541203, Waltham, MA 02453]. We will make the requested change(s) and advise You of the new premium payable. The premium for the reduced coverage will be based on Your age when Your Policy was issued.

Unpaid Premium. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

Waiver of Premium During Benefit Period. UHIC will keep Your Policy in force and waive the payment of premiums for it during the Premium Waiver Period described below if it has been determined by Our Care Advisor that You meet the eligibility requirements for receipt of benefits.

Premiums will be waived on a month-by-month basis.

If premiums are being paid other than monthly, You will be placed on the monthly premium payment mode when We start to waive premiums. We will then refund any unearned monthly premiums, starting with the premium of the first full month for which premiums are waived.

Premium Waiver Period. The Premium Waiver Period begins the first day of the month following the day benefits become payable.

The Premium Waiver Period will end on the earliest of the following dates:

1. The date You no longer meet the eligibility requirements for benefits; or
2. The date You have exhausted the Maximum Lifetime Benefit payable under the Policy.

When the Premium Waiver Period ends, and if You have not exhausted the Maximum Lifetime Benefit amount payable under the Policy, Your coverage may be continued in force by payment of the first premium due after the date the Premium Waiver Period ends. The premium will be the same as in effect prior to the date the waiver of premium started, subject to any change in the premium rates which may have occurred as provided in the Premium Provisions.

Reinstatement of Coverage. If Your coverage terminates for non-payment of premium, coverage may be reinstated at Our option. You may request reinstatement up to six (6) months after termination of Your Policy.

We may require You to submit an application for reinstatement. If We require an application for reinstatement and issue a conditional receipt for the accepted premium, Your Policy will be reinstated upon approval of Your application for reinstatement; or, lacking such approval, Your

Policy will be reinstated no later than forty-five (45) days following the date of such conditional receipt, unless We have notified You in writing of the disapproval of Your application for reinstatement.

If We do not require an application for reinstatement, coverage will be reinstated as of the date We accept Your premium.

You must pay the premium due retroactively to the date Your Policy terminated.

The reinstated coverage will only apply to benefits that are provided after the date of reinstatement.

Reinstatement Due to Chronic Illness

If You fail to pay Your premium by the end of the Grace Period because You are Chronically Ill, You may request reinstatement up to six (6) months after termination of Your Policy.

Your Physician must submit proof that You are Chronically Ill and that caused You to fail to pay Your premium. We will require evidence of clinical diagnosis or tests demonstrating that You were Chronically Ill at the time of Policy termination before deciding on reinstatement.

If Your Policy is reinstated, You must pay the premium due retroactively to the date Your Policy terminated. No benefits will be paid for care or services received prior to the date We receive evidence from Your Physician of Your loss.

Section VI

When You Have A Claim

Notice of Claim. We must be given notice of claim within thirty (30) days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain Your name and enough information to identify You, and an address to which the claim form(s) should be sent. Notice may be mailed to [Administrative Office: P.O. Box 541203, Waltham, MA 02453-1203]. Notice may also be made by calling [877-272-3959].

Claim Forms. When We receive notice of claim, We will provide You with claim form(s) within fifteen (15) days after We receive notice. If We do not provide You with claim forms within fifteen (15) days after We receive Your notice of claim, You will be deemed to have complied with Our claim form requirements if, within the time fixed in the Policy for filing of Proof of Loss, You provide Us with written proof of the date(s) and exact nature of the charges You have incurred.

Proof of Loss. Written proof must be sent to Us within ninety (90) days after the date the loss occurs. If it was not reasonably possible to give Us written proof within ninety (90) days, We will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible, and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

Time of Payment of Claim. After We receive the proper written Proof of Loss, benefits will be paid immediately. Benefits will be paid monthly when the loss is expected to result in ongoing benefits. Benefits will be paid immediately when Our liability has ended.

Payment of Claims. All benefits are paid to You or to Your estate. If You have signed an assignment of benefits, Your benefits will be paid directly to the Care Provider. Any payment We make in good faith will fully release Us of Our responsibility to the extent of the payment.

Physical Examination. At Our expense, We may require You to undergo a physical examination when reasonably required while a claim is pending.

Extension of Benefits. If Your Policy lapses while benefits are payable for Qualified Long-Term Care services, it will not affect a claim beginning before the lapse. We will continue to pay benefits for Qualified Long-Term Care services beyond the date of the lapse for as long as You remain benefit eligible without interruption. Continuous nursing home confinement shall include being transferred to another nursing home or receiving another level of Nursing Care in a nursing home or for the transfer back to a nursing home from a temporary/acute hospitalization.

This Extension of Benefits is subject to Your Maximum Lifetime Benefit and all other Policy provisions.

Section VII

Appealing a Decision

You and the Company may not always agree that a claim or request for services has been reviewed properly. When this happens, You are encouraged to write to Our Customer Service Department at [United HealthCare Insurance Company, LTC Administration, P.O. Box 541203, Waltham, MA 02453].

If You disagree with a claim determination because We have partially or fully denied benefits, You may file an appeal and request that We review Our decision. The request must be sent to Us in writing, and must include Your reason for the request and any documents that You feel are pertinent to Your situation. The request should be sent to Us within sixty (60) business days after You receive Our denial.

You may designate a representative to file an appeal on Your behalf by providing written notice that includes the issue in dispute, Your signature and the representative's signature.

We will review Your request and notify You or Your representative of Our decision within ninety (90) business days of receiving the request. If a longer investigation period is required, We will notify You of the reason why and when a decision may be expected. In such case, We will provide a written decision within one-hundred twenty (120) days of receiving the request.

For determinations that the services are not Covered Services, the response will specify the provisions in the Policy that exclude that coverage.

Section VIII

General Provisions

Conformity to State and Federal Law. We amend any provision of the Policy that conflicts with state or federal law on the Policy Effective Date to the minimum requirements of the law.

Entire Contract; Changes. This Policy together with the Application, endorsements and riders, if any, make up the entire contract of insurance. No change in the Policy shall be valid unless approved in writing by one of Our officers. Any change must be noted on or attached hereto. No agent may change this Policy or waive any of its provisions.

Legal Actions. No legal action may be brought to recover against the Policy within sixty (60) days after written proof of loss has been given. No such action will be brought after three (3) years from the time written proof of loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where You live, the limit is extended to meet the minimum time allowed by such law.

Right to Receive Information. The Policyholder shall provide Us with the information necessary to administer coverage under the Policy.

Right of Recovery. If payment of claims exceeds the maximum amount payable under any benefit provisions or riders of the Policy, We have the right to recover the excess of such payments.

Misstatement of Age. If Your age was misstated on Your application, Your Policy premium or amounts of coverage will be changed to correspond to Your correct age at the date this Policy was issued.

Incontestability. During the first six (6) months Your Policy is in force, We may rescind Your Policy or deny an otherwise valid long-term care insurance claim upon showing of misrepresentation by You that was material to the acceptance for coverage.

After six (6) months but before two (2) years of Policy coverage, We may rescind Your Policy or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that was both material to the acceptance of coverage and which pertained to the condition for which benefits are sought.

After Your Policy has been in force for two (2) years, We may rescind Your Policy or deny an otherwise valid long-term care insurance claim only upon a showing that You knowingly and intentionally misrepresented relevant facts relating to Your health.

We will refund the full amount of any premium paid and this Policy will be considered void from the start if We rescind Your Policy.

If benefit payments have been made under this Policy, We may not recover such payments should We void Your Policy.

Waiver of Rights. Our failure to enforce any provision of the Policy does not affect Our right to enforce any provision at a later date, and does not affect Our right to enforce any other provision of the Policy.

Portability. This Policy recognizes Qualified Long-Term Care services provided to You anywhere in the United States by Providers duly licensed or certified in accordance with applicable state or federal law.

Section IX

When Coverage Ends

Your insurance ends on the earliest of:

1. The date You cancel or do not renew the Policy; or
2. On the expiration of the grace period, if the required premium is not paid, unless premium is being waived; or
3. The date We discover any false representations or concealment of material facts upon enrollment; or
4. The date the Lifetime Benefit Maximum has been exhausted; or
5. The date of Your death.

UNITED HEALTHCARE INSURANCE COMPANY (UHC)
Home Office: [450 Columbus Boulevard, Hartford, CT 06115]

Administrative Office: [P.O. Box 541203, Waltham, MA 02453-1203, 800-555-5555]

TAX-QUALIFIED LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE
[LTC POL 1000]

Caution: The issuance of a long-term care insurance policy is based upon your responses to the questions on the application. A copy of the application will be enclosed with the policy. If your answers are incorrect or untrue, we have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at the address or toll-free telephone number listed above.

Notice to Buyer: The policy may not cover all of the costs associated with long-term care, which may be incurred by you during the period of coverage. You are advised to periodically review the policy in relation to the changes in the cost of long-term care. The policy is subject to certain coverage limitations and exclusions. You are advised to carefully review all limitations and exclusions.

1. The policy is an individual policy. The policy will meet the minimum requirements for long-term care in the state in which you reside.
2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual policy contains governing contractual provisions. This means that the policy sets forth in detail your rights and obligations and our rights and obligations. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ THE POLICY CAREFULLY!**
3. **FEDERAL TAX CONSEQUENCES.** The policy is intended to be a federally tax-qualified long-term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986 as amended.
4. **TERMS UNDER WHICH THE CONTRACT MAY BE CONTINUED IN FORCE OR DISCONTINUED.**
 - (a) **RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. UnitedHealthcare Insurance Company cannot change any of the terms of your policy on its own, except that, in the future, WE MAY INCREASE THE PREMIUM YOU PAY.

- (b) Waiver of Premium: The premium waiver period begins the first day of the month following the day benefits become payable. When the premium waiver period ends, and if you have not exhausted the Maximum Lifetime Benefit amount payable under the policy, your coverage may be continued in force by payment of the first premium due after the date the premium waiver period ends.
5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS. The policy is guaranteed renewable. We will not change your premiums because of age or health. We may, however, change your premiums on a class basis, subject to applicable state insurance department approval, but only if we change the premiums for all policyholders in the same class. We will notify you of any premium change at least [forty-five (45)] days before the premium due date on which your premiums change.
6. TERMS UNDER WHICH THE CONTRACT MAY BE RETURNED AND PREMIUM REFUNDED.
- (a) Thirty Day Right to Examine Policy: If you are not satisfied for any reason, you may return your policy within thirty (30) days after receipt. The premium will be refunded, less any claims paid during this period. When so returned, the policy is void from the beginning. Return the policy to us at [Administrative Office: P.O. Box 541203, Waltham, MA 02453-1203].
- (b) Return of Unearned Premium: We will make a pro-rata refund of premium paid for the period beyond the date of your cancellation or death. We will pay the refund directly to you or your estate.
7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from UHIC.
- Neither the UHIC nor its agents represent Medicare, the federal government or any state government.
8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.
- The policy provides coverage on an expense incurred basis for Qualified Long-Term Care Services, subject to the Maximum Daily Benefit, the Maximum Lifetime Benefit, the Lifetime Waiting Period and all policy provisions.
9. BENEFITS PROVIDED BY THE POLICY.
- Benefit Eligibility: To be eligible for benefits provided by the policy, you must be certified as Chronically Ill pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Eligibility for the Payment of Benefits: Benefits are payable only for Qualified Long-Term Care Services. All benefits are subject to your Maximum Lifetime Benefit. Certain benefits are subject to your Maximum Daily Benefit and Lifetime Waiting Period.

Facility Benefits

We will pay one hundred percent 100% of the expenses you incur for care rendered in a Skilled Nursing Facility, Assisted Living Facility or Hospice facility up to the Maximum Daily Benefit and Maximum Lifetime Benefit subject to the Lifetime Waiting Period.

Home and Community Benefits

We will pay one hundred percent (100%) of the expenses you incur for Home Health Care Services, Adult Day Care, Homemaker Services or Hospice Care rendered in your home or other community-based setting up to the Maximum Daily Benefit and Maximum Lifetime Benefit.

Days for which Home and Community Benefits are paid will count toward satisfying the Lifetime Waiting Period for Facility Benefits.

Alternative Plan of Care Benefit

We may pay for alternative benefits for Qualified Long-Term Care Services that are medically acceptable, cost effective and agreed to by you, us and your Physician up to the Maximum Daily Benefit and the Maximum Lifetime Benefit.

You maintain the right to discontinue the Alternative Plan of Care Benefit and resume receiving benefits as defined in the policy.

Bed Reservation Benefit

We will pay one hundred percent (100%) of the expenses you incur to reserve your bed, if you are hospitalized temporarily while receiving eligible services in a facility covered under this policy and that facility charges you a fee to reserve your bed, for up to [twenty-one (21)] days per calendar year subject to the Maximum Daily Benefit and Maximum Lifetime Benefit.

Caregiver Training Benefit

We will pay one hundred percent (100%) of the expenses you incur for Caregiver Training received by an informal (unpaid) caregiver for up to the Caregiver Training Lifetime Benefit as shown on the Schedule Page. This benefit is not subject to the Maximum Daily Benefit, but it is subject to the Maximum Lifetime Benefit.

There is no Lifetime Waiting Period for the Caregiver Training Benefit. Days for which the Caregiver Training Benefit is paid will not count toward satisfying the Lifetime Waiting Period.

Home Modification Benefit

We will pay one hundred percent (100%) of the expenses you incur for: (a) structural modification to your home that will allow you to remain in your home; or (b) medical equipment designed and used to treat a sickness or injury for up to the Home Modification Lifetime Benefit as shown on the Schedule Page. This benefit is

not subject to the Maximum Daily Benefit, but it is subject to the Maximum Lifetime Benefit.

There is no Lifetime Waiting Period for the Home Modification Benefit. Days for which the Home Modification Benefit is paid will not count toward satisfying the Lifetime Waiting Period.

Respite Care Benefit

We will pay one hundred percent (100%) of the expenses you incur for each day you receive Respite Care provided at home or in an approved facility for up to twenty-one (21)] days per calendar year up to the Maximum Daily Benefit and Maximum Lifetime Benefit.

There is no Lifetime Waiting Period for the Respite Care Benefit. Days for which the Respite Care Benefit is paid will not count toward satisfying the Lifetime Waiting Period.

Contingent Benefit Upon Lapse

The Contingent Benefit upon Lapse shall be triggered if we increase the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the initial annual premium as set forth in the table below, and the policy lapses within one-hundred twenty (120) days of the due date of the premium so increased. You will be notified at least forty-five (45) days prior to the due date of the premium reflecting the rate increase.

On or before the effective date of a substantial premium increase as defined above, you will have the option to:

1. Reduce policy benefits provided by your current coverage without additional underwriting so that required premium payments are not increased; or
2. Convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms described below. This option may be elected at any time during the one-hundred twenty (120) day period referenced above.

If there is a default or lapse in coverage at any time during the one-hundred twenty one-hundred twenty (120) day period referenced above, you shall be considered to have chosen the offer to convert in paragraph number two (2) above.

A shortened benefit period provides paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but no increases thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits will be subject to the following limits:

1. one-hundred percent (100%) of the sum of all premiums paid for this policy, including the premiums paid prior to any changes in benefits; or
2. thirty (30) times the Maximum Daily Benefit Amount in effect at the time of lapse.

However, the total benefits payable under the policy for a period of care, including this Contingent Benefit upon Lapse, will not exceed the Maximum Policy Benefit listed in the Schedule.

Triggers for Contingent Benefit Upon Lapse

<u>Issue Age</u>	<u>Substantial Percent Over Initial Premium</u>	<u>Issue Age</u>	<u>Substantial Percent Over Initial Premium</u>	<u>Issue Age</u>	<u>Substantial Percent Over Initial Premium</u>
29 and under	200%	66	48%	79	22%
30-34	190%	67	46%	80	20%
35-39	170%	68	44%	81	19%
40-44	150%	69	42%	82	18%
45-49	130%	70	40%	83	17%
50-54	110%	71	38%	84	16%
55-59	90%	72	36%	85	15%
60	70%	73	34%	86	14%
61	66%	74	32%	87	13%
62	62%	75	30%	88	12%
63	58%	76	28%	89	11%
64	54%	77	26%	90 and over	10%
65	50%	78	24%		

OPTIONAL BENEFITS

Nonforfeiture Benefit Rider

If chosen, UHIC will establish a shortened benefit period based on the length of time the policy was in force and subsequently lapsed according to the terms set in the rider.

Important Terms:

1. Activities of Daily Living include the following functions and are used as one measure to determine your eligibility for benefits:
 - (a) Bathing: washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower;
 - (b) Continence: ability to maintain control of bowel and bladder function or, when not able to maintain control of bowel or bladder function, the ability to perform related personal hygiene (including caring for catheter or colostomy bag);
 - (c) Dressing: putting on and taking off all items of clothing and any required braces, fasteners, or artificial limbs;
 - (d) Eating: feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously;
 - (e) Toileting: getting to and from the toilet, getting on and off the toilet, and performing related personal hygiene;
 - (f) Transferring: moving into or out of a bed, chair or wheelchair.

2. Chronically Ill means that within the preceding twelve (12) months, you have been certified by a Licensed Health Care Practitioner as:
 1. being unable to perform without Substantial Assistance from another individual two (2) or more of the Activities of Daily Living for a period expected to last at least ninety (90) days due to a loss of functional capacity; or
 2. requiring Substantial Supervision to protect you from threats to health and safety due to Severe Cognitive Impairment.

Written certification must be renewed or updated at least every twelve (12) months.

3. Lifetime Waiting Period means the number of days after the Policy Effective Date during which you are both: (1) Chronically Ill; and (2) receiving paid Qualified Long-Term Care services before you can receive benefits. These days need not be consecutive. Benefits will not be paid for services you receive during the Lifetime Waiting Period. The Lifetime Waiting Period must be satisfied only once during the life of the Policy.
4. Maximum Daily Benefit means the greatest amount that we will pay for all expenses combined that you incur on any one day under all benefits available under the policy. An expense is considered to be incurred on the day on which the care or service is received.
5. Maximum Lifetime Benefit means the amount that result by multiplying the Maximum Daily Benefit by the number of Benefit Period days that has been elected by the policyholder.
6. Qualified Long-Term Care means services for necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and Maintenance or Personal Care services which are required by a Chronically Ill individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.
7. Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that: (a) is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and (b) is measured by clinical evidence and standardized tests that reliably measure impairment in the person's (i) short-term or long-term memory; (ii) orientation as to people, places or time; (iii) and deductive or abstract reasoning.

10. LIMITATIONS AND EXCLUSIONS.

- (a) There are no pre-existing condition limitations for the policy;
- (b) The policy will not pay benefits for any care services that are:

- Services for which benefits are payable under Medicare or other governmental program, except Medicaid; any state or Federal workers' compensation, employer's liability or occupational disease law; a motor vehicle no-fault law;
- Mental or Nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;
- Treatment provided in a government facility, unless a charge is made and you are legally obligated to pay;
- Services provided by family members unless: (a) he or she is a regular employee of a home health care agency; (b) the home health care agency receives payment for the services; and (c) he or she receives no compensation other than the normal compensation for employees of that home health care agency;
- Illness or medical condition arising out of war or any act of war, declared or undeclared while serving in the military service or any auxiliary unit attached thereto;
- Services for attempted suicide or intentionally self-inflicted injury;
- Services received outside the United States and its possessions;
- Services and supplies not in the Plan of Care;
- Alcoholism, drug addiction, or chemical dependency unless as a result of medication as prescribed by a Physician ; and
- Services for which no charge is normally made in the absence of insurance.

THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted.

The policy includes an Automatic Inflation Increases provision. The Maximum Daily Benefit amount will be increased by five percent (5%) compounded annually on each Policy Anniversary date. Any time the Maximum Daily Benefit amount changes under this section, the Maximum Lifetime Benefit will be increased by five percent (5%) of the Remaining Lifetime Benefit. The Remaining Lifetime Benefit on the current Policy Anniversary is the Maximum Lifetime Benefit on the previous Policy Anniversary less the total of all claims paid up to the current Policy Anniversary.

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

The policy pays a benefit if you are a Chronically Ill due to Severe Cognitive Impairment resulting from Alzheimer's Disease or other forms of irreversible dementias.

13. PREMIUM.

Long-Term Care Insurance Policy	\$ _____
Nonforfeiture Benefit Rider	\$ _____
Spousal or Marital Discount, if applicable	\$ _____
Total Annual Premium	\$ _____

The amount of premium for the policy is dependent upon your selections of Maximum Daily Benefit and Maximum Lifetime Benefit.

14. ADDITIONAL FEATURES.

(a) Medical Underwriting: The policy will be issued based on your answers to the questions on the application and any additional information that may be needed to complete the evaluation process.

(b) Unintentional Lapse: In addition to yourself, you have a right to designate another individual to receive notification of lapse or termination. If the premium is not paid by the end of the grace period, we will inform both you and, if chosen, the designated individual at least thirty-one (31) days before the effective date of lapse. The notice will be given by first class United States mail, postage prepaid, to you and to the designated individual. Notice is considered to have been given as of five (5) days after the date of mailing.

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT UHIC IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY.

UNITED HEALTHCARE INSURANCE COMPANY (UHIC)

Home Office: [450 Columbus Boulevard, Hartford, CT 06115]

Administrative Office: [P.O. Box 541203, Waltham, MA 02453-1203, 877-272-3959]

Nonforfeiture Benefit Rider

After Your Policy has been in force for three (3) years, this Rider provides for continuation of coverage if You stop paying Premiums because of nonpayment of premiums or Your written request to cancel the policy.

The same benefit amounts as those payable in effect under the policy immediately prior to the effective date of the nonforfeiture will be payable under this Rider except that the Lifetime Benefit will be the greater of:

1. 100% of the sum of all premiums paid or waived under the terms of this policy; or
2. thirty (30) times the Maximum Daily Benefit in effect immediately prior to the effective date of the nonforfeiture.

The total Benefits available under the policy after the effective date of the nonforfeiture will not be more than the remaining Maximum Lifetime Benefit when Your policy ended because of nonpayment of premiums or Your written request to cancel the policy.

Once the Nonforfeiture Benefit becomes effective You cannot make any changes to Your policy. Inflation increases under the Automatic Inflation Increases provision will be discontinued when Premium payments cease.

This Rider will end on the earlier of:

1. We receive Your written request to cancel this Rider; or
2. the date on which the policy ends.

In all other respects, the provisions and conditions of the policy remain the same. This Rider is subject to the provisions of the policy.

Signed for United HealthCare Insurance Company

President

This step determines your eligibility for coverage under the United HealthCare Insurance Company (UnitedHealthcare) Long-Term Care policy, so please answer all of the questions on this page before completing any other part of this application.

1. Do you currently:

- ☐ Yes ☐ No Use or require the use of any mechanical or medical devices such as a wheelchair, walker, multi-prong cane, crutches, hospital bed, dialysis, respirator oxygen, motorized cart or stair lift?
- ☐ Yes ☐ No Need help, assistance or supervision in doing any of the following: bathing, eating, dressing, toileting, walking, transferring or maintaining continence?
- ☐ Yes ☐ No Need help, assistance or supervision in performing two or more of the following everyday activities: taking medication, doing housework, laundry, shopping or meal preparation?

2. ☐ Yes ☐ No Within the past two years, has a person or institution acted on your behalf due to any mental or physical disability?

3. Have you ever experienced symptoms of, been diagnosed with, consulted a medical professional for, been treated for or advised to be treated for:

- | | | | |
|--|--|--|---|
| <input type="radio"/> Yes <input type="radio"/> No | Cancer which has spread from the original site or organ | <input type="radio"/> Yes <input type="radio"/> No | Lou Gehrig's Disease (ALS) |
| <input type="radio"/> Yes <input type="radio"/> No | Hodgkin's Disease | <input type="radio"/> Yes <input type="radio"/> No | Demyelinating Disease |
| <input type="radio"/> Yes <input type="radio"/> No | Lymphoma | <input type="radio"/> Yes <input type="radio"/> No | Multiple Sclerosis |
| <input type="radio"/> Yes <input type="radio"/> No | Multiple Myeloma | <input type="radio"/> Yes <input type="radio"/> No | Myasthenia Gravis |
| <input type="radio"/> Yes <input type="radio"/> No | Scleroderma | <input type="radio"/> Yes <input type="radio"/> No | Transverse Myelitis |
| <input type="radio"/> Yes <input type="radio"/> No | Systemic Lupus Erythematosus | <input type="radio"/> Yes <input type="radio"/> No | Dialysis (kidney) |
| <input type="radio"/> Yes <input type="radio"/> No | Sarcoidosis | <input type="radio"/> Yes <input type="radio"/> No | Renal Failure |
| <input type="radio"/> Yes <input type="radio"/> No | Pulmonary Fibrosis | <input type="radio"/> Yes <input type="radio"/> No | Nephritis |
| <input type="radio"/> Yes <input type="radio"/> No | Cystic Fibrosis | <input type="radio"/> Yes <input type="radio"/> No | Polycystic Kidney Disease |
| <input type="radio"/> Yes <input type="radio"/> No | Alzheimer's Disease | <input type="radio"/> Yes <input type="radio"/> No | Paralysis |
| <input type="radio"/> Yes <input type="radio"/> No | Memory Loss | <input type="radio"/> Yes <input type="radio"/> No | Amputation of more than one limb |
| <input type="radio"/> Yes <input type="radio"/> No | Senility | <input type="radio"/> Yes <input type="radio"/> No | Condition which causes limited motion |
| <input type="radio"/> Yes <input type="radio"/> No | Dementia | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis (chronic or active) |
| <input type="radio"/> Yes <input type="radio"/> No | Organic Brain Syndrome | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease |
| <input type="radio"/> Yes <input type="radio"/> No | Schizophrenia | <input type="radio"/> Yes <input type="radio"/> No | Cirrhosis |
| <input type="radio"/> Yes <input type="radio"/> No | Psychosis | <input type="radio"/> Yes <input type="radio"/> No | Organ Transplant (other than kidney or cornea) |
| <input type="radio"/> Yes <input type="radio"/> No | More than one stroke/mini-stroke/or combination of Transient Ischemic Attack (TIA) | <input type="radio"/> Yes <input type="radio"/> No | Chronic Fatigue Syndrome |
| <input type="radio"/> Yes <input type="radio"/> No | Parkinson's Disease | <input type="radio"/> Yes <input type="radio"/> No | Acquired Immune Deficiency Syndrome (AIDS) |
| <input type="radio"/> Yes <input type="radio"/> No | Muscular Dystrophy | <input type="radio"/> Yes <input type="radio"/> No | AIDS-related complex |
| <input type="radio"/> Yes <input type="radio"/> No | Huntington's Chorea | <input type="radio"/> Yes <input type="radio"/> No | AIDS-related conditions (tested positive for HIV) |
| <input type="radio"/> Yes <input type="radio"/> No | Motor Neuron Disease | | |

[If you answered "Yes" to any question on this page, we regret that coverage is not available to you.]

Applicant information

1. To facilitate processing, please print clearly and complete all information.

First/Middle initial/Last name:	Gender: <input type="radio"/> Male <input type="radio"/> Female
Address:	Date of birth:
City/State/ZIP:	Social Security #:
Home phone:	Marital status: <input type="radio"/> Single <input type="radio"/> Married (Please check "single" if you are widowed or divorced.)
Work phone:	

2. To qualify for a spouse/partner discount, please indicate the following:

☐ Yes ☐ No Is your spouse/partner applying for coverage?

☐ Yes ☐ No Does your spouse/partner have a Long-Term Care policy with us?

If "Yes," list your spouse's/partner's name: _____

Last four digits of SSN: _____

DOB: _____

Choose a benefit level and options

1. Select an application type:

☐ This is a request for a new policy.

☐ I currently have a [UnitedHealth at Home Short-Term Care Policy] and wish to upgrade to a Long-Term Care policy.

Existing [Short-Term Care] policy number: _____

☐ I currently have a [UnitedHealth at Home Short-Term Care Policy]. I wish to purchase a Long-Term Care policy and retain my [UnitedHealth at Home Short-Term Care Policy] rather than replace it. I understand that the lifetime waiting period on this Long-Term Care product will be increased to reflect the length of the benefit period of my Short-Term Care policy so that there is no overlap in coverage.

Existing [Short-Term Care] policy number: _____

☐ I currently have a Long-Term Care policy and wish to change my daily benefit amount and/or length of total lifetime benefit.

2. Daily Benefit Amount (DBA):

\$ _____ per day (Choose from [\$50]–[\$400] in [\$10] increments.)

3. Total Benefit Period:

- ☐ [2 years (24 months)]
- ☐ [3 years (36 months)]
- ☐ [4 years (48 months)]

4. I elect to have optional nonforfeiture coverage ☐ Yes ☐ No

Check here to confirm:

☐ I have been offered the option to purchase nonforfeiture coverage.

SIGN HERE IF YOU **REJECT** THIS OFFER _____

I have reviewed the outline of coverage and the nonforfeiture coverage as described therein. Specifically, I have reviewed the plan with nonforfeiture coverage, and I reject the nonforfeiture coverage.

Please note: If you select “No,” you will automatically receive the contingent benefits upon lapse of coverage for no additional premium.

Choose a payment method

1. Select one: (Please note: You can save money by paying your premium annually.)

<input type="radio"/> Check/Cash (monthly payment <u>not</u> available)	Select frequency: <input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Semiannually <input type="radio"/> Annually	Estimated premium: _____ _____ _____ _____
<input type="radio"/> Credit/Debit card: Please charge my premium. Type _____ Account # _____ Expiration date _____ Signature _____		
<input type="radio"/> Health Savings Account (HSA) card Type _____ Account # _____ Expiration date _____ Signature _____		
<input type="radio"/> Automatic checking account deduction/Electronic funds transfer: Monthly only Your monthly premium will be deducted automatically from the bank or credit union checking account you request. Complete the information below and, if possible, enclose a voided blank check for the account you wish to use. If using a credit union account, provide credit union phone #: (____) _____. Routing Number: _____ (To locate the routing number, simply look at the bottom left-hand corner of the check. The first set of numbers listed is the routing number.) Account Number: _____ (To locate the account number, look at the bottom of the check, to the right of the routing number.) <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 2px;"> 08 20 1 2 7 1 4 1 </div> <div style="border: 1px solid black; padding: 2px;"> 0 7 1 1 2 5 2 1 8 7 </div> </div> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 2px;">Routing Number</div> <div style="border: 1px solid black; padding: 2px;">Account Number</div> </div> <p>I authorize: (1) UnitedHealthcare to initiate monthly deductions from my checking account, by electronic or other means, as payment for the coverage level selected; and (2) the financial institution on which my designated account is drawn to: (a) accept the deductions initiated by UnitedHealthcare; and (b) give UnitedHealthcare my most recent address upon UnitedHealthcare's request. Deductions will continue until UnitedHealthcare has had a reasonable opportunity to act upon my written request to end this service. I authorize deductions to be taken on the ____ day of the month, or the next business day. If no day is selected, deductions will be taken on the first business day of the month.</p> <div style="display: flex; justify-content: space-between;"> <div>Signature of account holder for monthly automatic deductions</div> <div>Date</div> </div>		

2. Protection against unintended lapse:

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Would you like to name a person in addition to yourself to receive notice if your coverage is about to lapse due to lack of premium payment?

Please note: This person will **NOT** be responsible for payment of premiums.

☐ **Yes** Please provide all information requested.

Full name _____ Relationship _____

Address _____ Telephone (____) _____

City _____ State _____ ZIP _____

☐ **No** **SIGN HERE** IF YOU **REJECT** THIS OFFER _____

Signature of applicant

Questions about existing coverage

You **MUST** answer all questions or we will not be able to process this application. Regulations of certain states require that we ask the following questions if you are applying for insurance.

- 1.** ☐ Yes ☐ No **Do you have another long-term care insurance policy or certificate in force (including a health care service contract or a health maintenance organization contract)?**
If “Yes,” list the types and amounts of coverage: _____

- 2.** ☐ Yes ☐ No **Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?**
If “Yes,” list insurance company: _____
If that policy or certificate lapsed, provide date: _____
- 3.** ☐ Yes ☐ No **Have you ever been declined or rated for long-term care coverage in the past?**
If “Yes,” complete information.
Date _____
Reason _____
- 4.** ☐ Yes ☐ No **Are you covered under Medicaid? (“Medicaid” is different from “Medicare.”)**
If you are eligible or covered by Medicaid, you may not need to purchase the policy since it may provide duplicate benefits.
- 5.** ☐ Yes ☐ No **Do you intend to replace any of your long-term care, medical or health insurance coverages with this policy?**
If “Yes,” complete information.
Policy number _____
Insurance company name _____
Insurance company address _____

For producer only:

- 6.** **Please list other health insurance policies sold by you to the applicant that are still in force:**

- 7.** **Please list insurance policies sold by you in the last five years to the applicant that are no longer in force:**

Required information: Please check to indicate that you have received the following items.

- ☐ **Outline of coverage**
- ☐ **Rate disclosure form**
- ☐ **Shopper's guide to long-term care**
- ☐ **Replacement notice** (if this is a replacement policy)
- ☐ **Consumer privacy notice**

I represent that all information supplied in this application is true and complete. I understand that, if this is an application for a new policy, UnitedHealthcare will have no liability until a policy is approved and the first full premium is paid. The policy will then be in effect, subject to the terms set forth in the next paragraph. If this is an application for a coverage change, then the coverage change will take effect on the effective date of the change.

I understand that: (1) the policy, if no receipt of premium has been issued; or (2) any coverage change that I am applying for, will not take effect unless on the date the policy is delivered to me or on the date such coverage change would otherwise be effective: (a) the condition of my health is the same as given in this application; and (b) I have not received any medical advice or treatment from a physician or other health care provider since the date of this application. I agree that I will inform UnitedHealthcare if there is a change in my health or if I have received any medical advice or treatment, as described above, between the date of this application and: (1) the date the policy is approved; or (2) the date on which any coverage change is scheduled to go into effect. Wherever my signature appears in this application, it shall have the same force and effect as if I had signed my name in full on the date shown below.

I have read the above answers and statements on this application. I declare that they are true and complete.

Caution: If your answers or statements on this application are incorrect or untrue, UnitedHealthcare may have the right to deny benefits or rescind your policy.

Fraud warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

SIGN HERE_____
Signature of applicant_____
Printed name of applicant_____
Date**SIGN HERE**_____
Signature of witness (spouse, producer or other)_____
Printed name of witness (spouse, producer or other)_____
Date**For producer only**

I certify that: (1) the information supplied by the applicant has been truly and accurately recorded on this application; (2) I am not aware of any other information relating to the applicant's health which might have been a bearing on the risk; and (3) the information was taken from the applicant in person.

Signed and dated in: _____ on _____, _____
State Month Date Year

SIGN HERE_____
Signature of producer

In connection with my application for a long-term care insurance policy, for underwriting and claim purposes, I authorize:

Any medical practitioner or facility or related entity; any insurer, employer, group policyholder, contract holder or benefit plan administrator to give UnitedHealthcare or any third party acting on UnitedHealthcare's behalf in this regard:

- personal information and data about me from sources including credit reports and motor vehicles history;
- information, records, and data about drugs prescribed, medical test results, and sexually transmitted diseases including records from the Medical Information Bureau;
- information, records and data about me related to alcohol and drug abuse and treatment, including information, records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results; and
- information, records and data about me relating to mental illness, other than psychotherapy notes.

Expiration, revocation and refusal to sign:

This authorization will expire 24 months from the date on this form or sooner if prescribed by law. I understand that, unless permitted by applicable law, I cannot revoke this authorization: (1) to the extent that UnitedHealthcare has taken action relying on the authorization; or (2) if UnitedHealthcare obtained the authorization as a condition to my obtaining insurance coverage. In all other cases, I understand that I may revoke it at any time. To revoke the authorization, I must write to UnitedHealthcare at [PO Box 541203, Waltham, MA 02453-1203] and inform UnitedHealthcare that this authorization is revoked. Any action taken before UnitedHealthcare receives my revocation will be valid. Revocation may be the basis for denying coverage or benefits. If I do not sign this authorization, my application for long-term care insurance cannot be processed.

By signing below, I acknowledge my understanding that:

- All or part of the information, records and data that UnitedHealthcare receives pursuant to this authorization may be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for UnitedHealthcare on the insurance applied for or on existing insurance with UnitedHealthcare, or disclosed as otherwise required or permitted by applicable laws.
- Medical Information Bureau records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans, and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to UnitedHealthcare or upon redisclosure by UnitedHealthcare, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- I have a right to receive a copy of this form.

Please note: A photocopy of this form is as valid as the original form.

SIGN HERE_____
Signature of applicant_____
Printed name of applicant_____
Date

Medical Information Bureau notice: Information regarding your insurability will be treated as confidential. Insurer, or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

This step determines your eligibility for coverage under the United HealthCare Insurance Company (UnitedHealthcare) Long-Term Care policy, so please answer all of the questions on this page before completing any other part of this application.

1. Do you currently:

- ☐ Yes ☐ No Use or require the use of any mechanical or medical devices such as a wheelchair, walker, multi-prong cane, crutches, hospital bed, dialysis, respirator oxygen, motorized cart or stair lift?
- ☐ Yes ☐ No Need help, assistance or supervision in doing any of the following: bathing, eating, dressing, toileting, walking, transferring or maintaining continence?
- ☐ Yes ☐ No Need help, assistance or supervision in performing two or more of the following everyday activities: taking medication, doing housework, laundry, shopping or meal preparation?

2. ☐ Yes ☐ No Within the past two years, has a person or institution acted on your behalf due to any mental or physical disability?

3. Have you ever experienced symptoms of, been diagnosed with, consulted a medical professional for, been treated for or advised to be treated for:

- | | | | |
|--|--|--|---|
| <input type="radio"/> Yes <input type="radio"/> No | Cancer which has spread from the original site or organ | <input type="radio"/> Yes <input type="radio"/> No | Lou Gehrig's Disease (ALS) |
| <input type="radio"/> Yes <input type="radio"/> No | Hodgkin's Disease | <input type="radio"/> Yes <input type="radio"/> No | Demyelinating Disease |
| <input type="radio"/> Yes <input type="radio"/> No | Lymphoma | <input type="radio"/> Yes <input type="radio"/> No | Multiple Sclerosis |
| <input type="radio"/> Yes <input type="radio"/> No | Multiple Myeloma | <input type="radio"/> Yes <input type="radio"/> No | Myasthenia Gravis |
| <input type="radio"/> Yes <input type="radio"/> No | Scleroderma | <input type="radio"/> Yes <input type="radio"/> No | Transverse Myelitis |
| <input type="radio"/> Yes <input type="radio"/> No | Systemic Lupus Erythematosus | <input type="radio"/> Yes <input type="radio"/> No | Dialysis (kidney) |
| <input type="radio"/> Yes <input type="radio"/> No | Sarcoidosis | <input type="radio"/> Yes <input type="radio"/> No | Renal Failure |
| <input type="radio"/> Yes <input type="radio"/> No | Pulmonary Fibrosis | <input type="radio"/> Yes <input type="radio"/> No | Nephritis |
| <input type="radio"/> Yes <input type="radio"/> No | Cystic Fibrosis | <input type="radio"/> Yes <input type="radio"/> No | Polycystic Kidney Disease |
| <input type="radio"/> Yes <input type="radio"/> No | Alzheimer's Disease | <input type="radio"/> Yes <input type="radio"/> No | Paralysis |
| <input type="radio"/> Yes <input type="radio"/> No | Memory Loss | <input type="radio"/> Yes <input type="radio"/> No | Amputation of more than one limb |
| <input type="radio"/> Yes <input type="radio"/> No | Senility | <input type="radio"/> Yes <input type="radio"/> No | Condition which causes limited motion |
| <input type="radio"/> Yes <input type="radio"/> No | Dementia | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis (chronic or active) |
| <input type="radio"/> Yes <input type="radio"/> No | Organic Brain Syndrome | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease |
| <input type="radio"/> Yes <input type="radio"/> No | Schizophrenia | <input type="radio"/> Yes <input type="radio"/> No | Cirrhosis |
| <input type="radio"/> Yes <input type="radio"/> No | Psychosis | <input type="radio"/> Yes <input type="radio"/> No | Organ Transplant (other than kidney or cornea) |
| <input type="radio"/> Yes <input type="radio"/> No | More than one stroke/mini-stroke/or combination of Transient Ischemic Attack (TIA) | <input type="radio"/> Yes <input type="radio"/> No | Chronic Fatigue Syndrome |
| <input type="radio"/> Yes <input type="radio"/> No | Parkinson's Disease | <input type="radio"/> Yes <input type="radio"/> No | Acquired Immune Deficiency Syndrome (AIDS) |
| <input type="radio"/> Yes <input type="radio"/> No | Muscular Dystrophy | <input type="radio"/> Yes <input type="radio"/> No | AIDS-related complex |
| <input type="radio"/> Yes <input type="radio"/> No | Huntington's Chorea | <input type="radio"/> Yes <input type="radio"/> No | AIDS-related conditions (tested positive for HIV) |
| <input type="radio"/> Yes <input type="radio"/> No | Motor Neuron Disease | | |

[If you answered "Yes" to any question on this page, we regret that coverage is not available to you.]

- 4.** ☐ Yes ☐ No **Do you currently use any tobacco products AND have you ever been diagnosed or treated for one of the following conditions: Diabetes, Transient Ischemic Attack (TIA), Stroke, Peripheral Vascular Disease, Chronic Obtrusive Pulmonary Disease, Emphysema, Congestive Heart Failure or Asthma?**
- 5.** ☐ Yes ☐ No **Do you have diabetes AND have you ever been diagnosed or treated for any one of the following conditions: Transient Ischemic Attack (TIA), Stroke, Neuropathy, Kidney Disease, Retinopathy or Peripheral Vascular Disease?**
- 6.** ☐ Yes ☐ No **Have you been absent from work for more than 10 consecutive days, due to illness, in the past 24 months?**
- 7.** ☐ Yes ☐ No **Have you received any type of disability benefit, worker's compensation or Social Security Disability in the past 24 months?**
- 8.** ☐ Yes ☐ No **Have you ever been declined or rated for long-term care coverage in the past?**
If **"Yes,"** complete information.
Date _____
Reason _____

[If you answered "Yes" to any question on this page, we regret that coverage is not available to you.]

Applicant information

1. To facilitate processing, please print clearly and complete all information.

First/Middle initial/Last name:	Gender: <input type="radio"/> Male <input type="radio"/> Female
Address:	Date of birth:
City/State/ZIP:	Social Security #:
Home phone:	Marital status: <input type="radio"/> Single <input type="radio"/> Married (Please check "single" if you are widowed or divorced.)
Work phone:	

2. To qualify for a spouse/partner discount, please indicate the following:

☐ Yes ☐ No Is your spouse/partner applying for coverage?

☐ Yes ☐ No Does your spouse/partner have a Long-Term Care policy with us?

If "Yes," list your spouse's/partner's name: _____

Last four digits of SSN: _____

DOB: _____

Choose a benefit level and options

1. Select an application type:

☐ This is a request for a new policy.

☐ I currently have a [UnitedHealth at Home Short-Term Care Policy] and wish to upgrade to a Long-Term Care policy.

Existing [Short-Term Care] policy number: _____

☐ I currently have a [UnitedHealth at Home Short-Term Care Policy]. I wish to purchase a Long-Term Care policy and retain my [UnitedHealth at Home Short-Term Care Policy] rather than replace it. I understand that the lifetime waiting period on this Long-Term Care product will be increased to reflect the length of the benefit period of my Short-Term Care policy so that there is no overlap in coverage.

Existing [Short-Term Care] policy number: _____

☐ I currently have a Long-Term Care policy and wish to change my daily benefit amount and/or length of total lifetime benefit.

2. Daily Benefit Amount (DBA):

\$ _____ per day (Choose from [\$50]–[\$400] in [\$10] increments.)

3. Total Benefit Period:

- ☐ [2 years (24 months)]
- ☐ [3 years (36 months)]
- ☐ [4 years (48 months)]

4. I elect to have optional nonforfeiture coverage ☐ Yes ☐ No

Check here to confirm:
☐ I have been offered the option to purchase nonforfeiture coverage.

SIGN HERE IF YOU REJECT THIS OFFER _____

I have reviewed the outline of coverage and the nonforfeiture coverage as described therein. Specifically, I have reviewed the plan with nonforfeiture coverage, and I reject the nonforfeiture coverage.

Please note: If you select “No,” you will automatically receive the contingent benefits upon lapse of coverage for no additional premium.

Choose a payment method

If you are paying premiums yourself, select one of the payment methods listed below in Item # 1. If premiums are employer paid or payroll deducted, skip to Item # 2 - Protection against unintended lapse.

1. Select one: (Please note: You can save money by paying your premium annually.)

<input type="radio"/> Check/Cash (monthly payment <u>not</u> available)	Select frequency: <input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Semiannually <input type="radio"/> Annually	Estimated premium: _____ _____ _____ _____
<input type="radio"/> Credit/Debit card: Please charge my premium. Type _____ Account # _____ Expiration date _____ Signature _____		
<input type="radio"/> Health Savings Account (HSA) card Type _____ Account # _____ Expiration date _____ Signature _____		
<input type="radio"/> Automatic checking account deduction/Electronic funds transfer: Monthly only Your monthly premium will be deducted automatically from the bank or credit union checking account you request. Complete the information below and, if possible, enclose a voided blank check for the account you wish to use. If using a credit union account, provide credit union phone #: (_____) _____. Routing Number: _____ (To locate the routing number, simply look at the bottom left-hand corner of the check. The first set of numbers listed is the routing number.) Account Number: _____ (To locate the account number, look at the bottom of the check, to the right of the routing number.) <div><div>08 20 12 7 14</div><div>07 11252 18 7</div><div>Routing Number</div><div>Account Number</div></div> <p>I authorize: (1) UnitedHealthcare to initiate monthly deductions from my checking account, by electronic or other means, as payment for the coverage level selected; and (2) the financial institution on which my designated account is drawn to: (a) accept the deductions initiated by UnitedHealthcare; and (b) give UnitedHealthcare my most recent address upon UnitedHealthcare’s request. Deductions will continue until UnitedHealthcare has had a reasonable opportunity to act upon my written request to end this service. I authorize deductions to be taken on the _____ day of the month, or the next business day. If no day is selected, deductions will be taken on the first business day of the month.</p> <div><div>Signature of account holder for monthly automatic deductions</div><div>Date</div></div>		

2. Protection against unintended lapse:

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Would you like to name a person in addition to yourself to receive notice if your coverage is about to lapse due to lack of premium payment?

Please note: This person will **NOT** be responsible for payment of premiums.

☐ **Yes** Please provide all information requested.

Full name _____ Relationship _____

Address _____ Telephone (____) _____

City _____ State _____ ZIP _____

☐ **No** **SIGN HERE** IF YOU **REJECT** THIS OFFER _____
Signature of applicant

Questions about existing coverage

You **MUST** answer all questions or we will not be able to process this application. Regulations of certain states require that we ask the following questions if you are applying for insurance.

- 1.** ☐ Yes ☐ No **Do you have another long-term care insurance policy or certificate in force (including a health care service contract or a health maintenance organization contract)?**
If “Yes,” list the types and amounts of coverage: _____

- 2.** ☐ Yes ☐ No **Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?**
If “Yes,” list insurance company: _____
If that policy or certificate lapsed, provide date: _____
- 3.** ☐ Yes ☐ No **Have you ever been declined or rated for long-term care coverage in the past?**
If “Yes,” complete information.
Date _____
Reason _____
- 4.** ☐ Yes ☐ No **Are you covered under Medicaid? (“Medicaid” is different from “Medicare.”)**
If you are eligible or covered by Medicaid, you may not need to purchase the policy since it may provide duplicate benefits.
- 5.** ☐ Yes ☐ No **Do you intend to replace any of your long-term care, medical or health insurance coverages with this policy?**
If “Yes,” complete information.
Policy number _____
Insurance company name _____
Insurance company address _____

For producer only:

- 6.** **Please list other health insurance policies sold by you to the applicant that are still in force:**

- 7.** **Please list insurance policies sold by you in the last five years to the applicant that are no longer in force:**

Required information: Please check to indicate that you have received the following items.

- ☐ **Outline of coverage**
- ☐ **Rate disclosure form**
- ☐ **Shopper's guide to long-term care**
- ☐ **Replacement notice** (if this is a replacement policy)
- ☐ **Consumer privacy notice**

I represent that all information supplied in this application is true and complete. I understand that, if this is an application for a new policy, UnitedHealthcare will have no liability until a policy is approved and the first full premium is paid. The policy will then be in effect, subject to the terms set forth in the next paragraph. If this is an application for a coverage change, then the coverage change will take effect on the effective date of the change.

I understand that: (1) the policy, if no receipt of premium has been issued; or (2) any coverage change that I am applying for, will not take effect unless on the date the policy is delivered to me or on the date such coverage change would otherwise be effective: (a) the condition of my health is the same as given in this application; and (b) I have not received any medical advice or treatment from a physician or other health care provider since the date of this application. I agree that I will inform UnitedHealthcare if there is a change in my health or if I have received any medical advice or treatment, as described above, between the date of this application and: (1) the date the policy is approved; or (2) the date on which any coverage change is scheduled to go into effect. Wherever my signature appears in this application, it shall have the same force and effect as if I had signed my name in full on the date shown below.

I have read the above answers and statements on this application. I declare that they are true and complete.

Caution: If your answers or statements on this application are incorrect or untrue, UnitedHealthcare may have the right to deny benefits or rescind your policy.

Fraud warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

SIGN HERE_____
Signature of applicant_____
Printed name of applicant_____
Date**SIGN HERE**_____
Signature of witness (spouse, producer or other)_____
Printed name of witness (spouse, producer or other)_____
Date**For producer only**

I certify that: (1) the information supplied by the applicant has been truly and accurately recorded on this application; (2) I am not aware of any other information relating to the applicant's health which might have been a bearing on the risk; and (3) the information was taken from the applicant in person.

Signed and dated in: _____ on _____, _____
State Month Date Year

SIGN HERE_____
Signature of producer

In connection with my application for a long-term care insurance policy, for underwriting and claim purposes, I authorize:

Any medical practitioner or facility or related entity; any insurer, employer, group policyholder, contract holder or benefit plan administrator to give UnitedHealthcare or any third party acting on UnitedHealthcare's behalf in this regard:

- personal information and data about me from sources including credit reports and motor vehicles history;
- information, records, and data about drugs prescribed, medical test results, and sexually transmitted diseases including records from the Medical Information Bureau;
- information, records and data about me related to alcohol and drug abuse and treatment, including information, records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results; and
- information, records and data about me relating to mental illness, other than psychotherapy notes.

Expiration, revocation and refusal to sign:

This authorization will expire 24 months from the date on this form or sooner if prescribed by law. I understand that, unless permitted by applicable law, I cannot revoke this authorization: (1) to the extent that UnitedHealthcare has taken action relying on the authorization; or (2) if UnitedHealthcare obtained the authorization as a condition to my obtaining insurance coverage. In all other cases, I understand that I may revoke it at any time. To revoke the authorization, I must write to UnitedHealthcare at [PO Box 541203, Waltham, MA 02453-1203] and inform UnitedHealthcare that this authorization is revoked. Any action taken before UnitedHealthcare receives my revocation will be valid. Revocation may be the basis for denying coverage or benefits. If I do not sign this authorization, my application for long-term care insurance cannot be processed.

By signing below, I acknowledge my understanding that:

- All or part of the information, records and data that UnitedHealthcare receives pursuant to this authorization may be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for UnitedHealthcare on the insurance applied for or on existing insurance with UnitedHealthcare, or disclosed as otherwise required or permitted by applicable laws.
- Medical Information Bureau records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans, and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to UnitedHealthcare or upon redisclosure by UnitedHealthcare, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- I have a right to receive a copy of this form.

Please note: A photocopy of this form is as valid as the original form.

SIGN HERE_____
Signature of applicant_____
Printed name of applicant_____
Date

Medical Information Bureau notice: Information regarding your insurability will be treated as confidential. Insurer, or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Health information

1. Primary care physician:

Name:	Phone:
Address:	Date last seen:
City/State/ZIP:	

2. What is your height? _____

3. What is your weight? _____

4. ☐ Yes ☐ No Have you used any tobacco products (including smoking cessation therapy) in the past 24 months?

5. In the past 24 months, have you:

☐ Yes ☐ No Received treatment in a nursing home, assisted living, rehabilitation or convalescent facility?

☐ Yes ☐ No Received any type of disability benefit, workers' compensation or Social Security Disability?

☐ Yes ☐ No Received any home health care, physiotherapy or adult day care services?

☐ Yes ☐ No Been advised to seek care in a hospital, nursing home, psychiatric facility, assisted living, rehabilitation or convalescent facility or any other health care facility?

If "Yes," when and why _____

6. In the past 5 years have you:

☐ Yes ☐ No Been advised to have any medical testing or surgical procedures that have not been completed or are currently scheduled to be performed?

If "Yes," when and why _____

7. Within the past five years (60 months), have you been diagnosed with, consulted a medical professional for, been treated for or advised to be treated for:

- | | | | | | |
|---------------------------|--------------------------|--|---------------------------|--------------------------|---------------------------------------|
| <input type="radio"/> Yes | <input type="radio"/> No | Rheumatoid Arthritis | <input type="radio"/> Yes | <input type="radio"/> No | Heart Attack |
| <input type="radio"/> Yes | <input type="radio"/> No | Osteoarthritis | <input type="radio"/> Yes | <input type="radio"/> No | Heart Surgery |
| <input type="radio"/> Yes | <input type="radio"/> No | Degenerative Bone Disease | <input type="radio"/> Yes | <input type="radio"/> No | Chest Pain |
| <input type="radio"/> Yes | <input type="radio"/> No | Degenerative Joint Disease | <input type="radio"/> Yes | <input type="radio"/> No | Angina |
| <input type="radio"/> Yes | <input type="radio"/> No | Osteoporosis | <input type="radio"/> Yes | <input type="radio"/> No | Coronary Artery Disease |
| <input type="radio"/> Yes | <input type="radio"/> No | Amputation due to disease or medical condition | <input type="radio"/> Yes | <input type="radio"/> No | Bypass Surgery |
| <input type="radio"/> Yes | <input type="radio"/> No | Degenerative Disc Disease | <input type="radio"/> Yes | <input type="radio"/> No | Arrhythmia |
| <input type="radio"/> Yes | <input type="radio"/> No | Back condition or surgery | <input type="radio"/> Yes | <input type="radio"/> No | Hypertension |
| <input type="radio"/> Yes | <input type="radio"/> No | Neck condition or surgery | <input type="radio"/> Yes | <input type="radio"/> No | Palpitations |
| <input type="radio"/> Yes | <input type="radio"/> No | Hip joint condition or surgery | <input type="radio"/> Yes | <input type="radio"/> No | Irregular Heartbeat |
| <input type="radio"/> Yes | <input type="radio"/> No | Knee joint condition or surgery | <input type="radio"/> Yes | <input type="radio"/> No | Circulatory Disease or surgery |
| <input type="radio"/> Yes | <input type="radio"/> No | Shoulder joint condition or surgery | <input type="radio"/> Yes | <input type="radio"/> No | Vascular Disease or surgery |
| <input type="radio"/> Yes | <input type="radio"/> No | Other bone joint condition or surgery | <input type="radio"/> Yes | <input type="radio"/> No | Aneurysm |
| <input type="radio"/> Yes | <input type="radio"/> No | Amputation | <input type="radio"/> Yes | <input type="radio"/> No | Carotid Artery Disease or surgery |
| <input type="radio"/> Yes | <input type="radio"/> No | Ataxia | <input type="radio"/> Yes | <input type="radio"/> No | Single episode of stroke |
| <input type="radio"/> Yes | <input type="radio"/> No | Transverse Myelitis | <input type="radio"/> Yes | <input type="radio"/> No | Mini-stroke |
| <input type="radio"/> Yes | <input type="radio"/> No | Myasthenia Gravis | <input type="radio"/> Yes | <input type="radio"/> No | Transient Ischemic Attack (TIA) |
| <input type="radio"/> Yes | <input type="radio"/> No | Post-Polio Syndrome | <input type="radio"/> Yes | <input type="radio"/> No | Paralysis |
| <input type="radio"/> Yes | <input type="radio"/> No | Cancer | <input type="radio"/> Yes | <input type="radio"/> No | Blindness |
| <input type="radio"/> Yes | <input type="radio"/> No | Leukemia | <input type="radio"/> Yes | <input type="radio"/> No | Numbness |
| <input type="radio"/> Yes | <input type="radio"/> No | Melanoma | <input type="radio"/> Yes | <input type="radio"/> No | Tremors |
| <input type="radio"/> Yes | <input type="radio"/> No | Tumor | <input type="radio"/> Yes | <input type="radio"/> No | Imbalance |
| <input type="radio"/> Yes | <input type="radio"/> No | Anemia | <input type="radio"/> Yes | <input type="radio"/> No | Condition causing limited motion |
| <input type="radio"/> Yes | <input type="radio"/> No | Platelet Disorder | <input type="radio"/> Yes | <input type="radio"/> No | Mental or nervous disorders |
| <input type="radio"/> Yes | <input type="radio"/> No | Hemophilia | <input type="radio"/> Yes | <input type="radio"/> No | Psychosis |
| <input type="radio"/> Yes | <input type="radio"/> No | Hemochromatosis | <input type="radio"/> Yes | <input type="radio"/> No | Depression |
| <input type="radio"/> Yes | <input type="radio"/> No | Diabetes | <input type="radio"/> Yes | <input type="radio"/> No | Anxiety |
| <input type="radio"/> Yes | <input type="radio"/> No | Glucose Metabolism Disorder | <input type="radio"/> Yes | <input type="radio"/> No | Attempted suicide |
| <input type="radio"/> Yes | <input type="radio"/> No | Thyroid problem | <input type="radio"/> Yes | <input type="radio"/> No | Alcohol overuse or abuse |
| <input type="radio"/> Yes | <input type="radio"/> No | Glandular problem | <input type="radio"/> Yes | <input type="radio"/> No | Drug overuse or abuse |
| <input type="radio"/> Yes | <input type="radio"/> No | Emphysema | <input type="radio"/> Yes | <input type="radio"/> No | Bulimia |
| <input type="radio"/> Yes | <input type="radio"/> No | Chronic Bronchitis | <input type="radio"/> Yes | <input type="radio"/> No | Anorexia |
| <input type="radio"/> Yes | <input type="radio"/> No | Chronic Obstructive Pulmonary Disease | <input type="radio"/> Yes | <input type="radio"/> No | Other eating disorder |
| <input type="radio"/> Yes | <input type="radio"/> No | Asthma | <input type="radio"/> Yes | <input type="radio"/> No | Kidney Disorder |
| <input type="radio"/> Yes | <input type="radio"/> No | Other lung or breathing condition | <input type="radio"/> Yes | <input type="radio"/> No | Prostate Disorder |
| <input type="radio"/> Yes | <input type="radio"/> No | Epilepsy | <input type="radio"/> Yes | <input type="radio"/> No | Bladder Disorder |
| <input type="radio"/> Yes | <input type="radio"/> No | Seizures | <input type="radio"/> Yes | <input type="radio"/> No | Lupus |
| <input type="radio"/> Yes | <input type="radio"/> No | Convulsions | <input type="radio"/> Yes | <input type="radio"/> No | Sarcoidosis |
| <input type="radio"/> Yes | <input type="radio"/> No | Fainting or Falls | <input type="radio"/> Yes | <input type="radio"/> No | Bronchiectasis |
| <input type="radio"/> Yes | <input type="radio"/> No | Chronic Fatigue | <input type="radio"/> Yes | <input type="radio"/> No | Macular Degeneration |
| <input type="radio"/> Yes | <input type="radio"/> No | Chronic Fatigue Syndrome | <input type="radio"/> Yes | <input type="radio"/> No | Glaucoma |
| <input type="radio"/> Yes | <input type="radio"/> No | Epstein-Barr Virus | <input type="radio"/> Yes | <input type="radio"/> No | Retinitis Pigmentosa |
| <input type="radio"/> Yes | <input type="radio"/> No | Fibromyalgia | <input type="radio"/> Yes | <input type="radio"/> No | Any other condition not listed above: |

Please note: For any “Yes” answers, give details on page 10.

Treatment information

If you have answered “Yes” to any question(s) on page 9, please provide treatment details below, and any applicable medication details on page 11.

Treating physician:	Date of diagnosis:
Condition:	Date of last symptom:
Treatment:	Date last seen:
Address and phone number of treating physician:	

Treating physician:	Date of diagnosis:
Condition:	Date of last symptom:
Treatment:	Date last seen:
Address and phone number of treating physician:	

Treating physician:	Date of diagnosis:
Condition:	Date of last symptom:
Treatment:	Date last seen:
Address and phone number of treating physician:	

Please use additional pages if you need more room.

Medication information

Please list any medications you have taken during the past 12 months.

Medication:	Dosage:
Reason prescribed:	Frequency:
Prescribing physician:	

Medication:	Dosage:
Reason prescribed:	Frequency:
Prescribing physician:	

Medication:	Dosage:
Reason prescribed:	Frequency:
Prescribing physician:	

☐ Yes ☐ No Other than the information provided previously, have you ever had any symptoms or complaints regarding your health for which you have not yet consulted a physician or received treatment?

If “Yes,” what and when _____

To the best of my knowledge and belief, the statements and answers given in this Health Questionnaire are true and complete.

SIGN HERE

Signature of applicant

Printed name of applicant

Date

Please use additional pages if you need more room.

Producer's copy

Received from _____ \$ _____ on _____
Printed name of applicant Amount Date

IMPORTANT: No coverage will be in effect until your application has been approved by UnitedHealthcare. Please note that receipt of your premium DOES NOT qualify you for coverage.

It is understood and agreed that payment of [two months] premium under this receipt of premium is made and accepted subject to the following conditions:

1. If, after we (UnitedHealthcare) receive: (a) the initial application requirements, as defined below; and (b) evidence of insurability acceptable to us, we determine that as of the date of the application, you are insurable based upon our underwriting criteria and standards for the insurance coverage applied for, the policy will take effect on the date the application was approved by UnitedHealthcare.
2. If we issue a policy to you, any unpaid balance of the full premium due, in accordance with the premium payment mode you have selected, must be paid upon delivery of the policy.

For purposes of this receipt, the initial application requirements are:

1. Completion of the application, in which you have answered "No" to all questions in Step 1 of the application.
2. Completion of an acceptable underwriting assessment, nurse interview, physical examination and assessment, if required by us.
3. Receipt by us of any attending physician statement(s), medical records and any other medical documents that we may require.
4. At least [two months] premium must be submitted in order for this receipt to become effective. The full amount of any check, draft or money order paid under this receipt must be honored on its first presentation for payment.

CAUTION: Your answers to all questions in the eligibility determination are relied upon to accept payment and issue this receipt. If any of these answers are incomplete or incorrect, or UnitedHealthcare is unable to approve the application within 75 days from the date of the application, the amount paid will be returned and this receipt will be null and void from the beginning.

If we determine that as of the date of the application you are not eligible for the insurance coverage applied for, coverage under this receipt will not become effective. There will be no coverage under the receipt of premium and the amount paid will be returned to you.

Limitations on authority: No one but the president, the secretary or a vice president of UnitedHealthcare may change or waive the terms of this receipt of premium. No producers, financial services representative or medical examiner has authority to determine insurability or to make or modify any contract of insurance or waive any of our requirements.

I have read this receipt of premium, and reviewed my answers to all questions in the eligibility determination. I represent that the answers to all those questions are true and complete. I understand and agree that if the answers to any of the questions in the eligibility determination are not true and complete, the amount tendered will be returned and this receipt of premium will be null and void from the beginning. I understand and agree to all of the terms of this receipt of premium. I have received a copy of this receipt of premium.

SIGN HERE

Signature of applicant

Printed name of applicant

Date

No producer or financial services representative is authorized to accept any payment with the application if you answered "Yes" to (or left blank) any of the questions in the eligibility determination.

Receipt of \$ _____ is acknowledged from _____ in connection with the application for long-term care insurance on this date _____.

SIGN HERE

Signature of producer

UnitedHealthcare makes no representations as to the tax consequences of the premium paid under this receipt or the benefits you receive under this receipt. Consult your own legal or tax advisor.

Please make all checks payable to [United HealthCare Insurance Company]. Do not make a check payable to the producer or sales representative and do not leave the payee blank.

Applicant's copy

Received from _____ \$ _____ on _____
Printed name of applicant Amount Date

IMPORTANT: No coverage will be in effect until your application has been approved by UnitedHealthcare. Please note that receipt of your premium DOES NOT qualify you for coverage.

It is understood and agreed that payment of [two months] premium under this receipt of premium is made and accepted subject to the following conditions:

1. If, after we (UnitedHealthcare) receive: (a) the initial application requirements, as defined below; and (b) evidence of insurability acceptable to us, we determine that as of the date of the application, you are insurable based upon our underwriting criteria and standards for the insurance coverage applied for, the policy will take effect on the date the application was approved by UnitedHealthcare.
2. If we issue a policy to you, any unpaid balance of the full premium due, in accordance with the premium payment mode you have selected, must be paid upon delivery of the policy.

For purposes of this receipt, the initial application requirements are:

1. Completion of the application, in which you have answered "No" to all questions in Step 1 of the application.
2. Completion of an acceptable underwriting assessment, nurse interview, physical examination and assessment, if required by us.
3. Receipt by us of any attending physician statement(s), medical records and any other medical documents that we may require.
4. At least [two months] premium must be submitted in order for this receipt to become effective. The full amount of any check, draft or money order paid under this receipt must be honored on its first presentation for payment.

CAUTION: Your answers to all questions in the eligibility determination are relied upon to accept payment and issue this receipt. If any of these answers are incomplete or incorrect, or UnitedHealthcare is unable to approve the application within 75 days from the date of the application, the amount paid will be returned and this receipt will be null and void from the beginning.

If we determine that as of the date of the application you are not eligible for the insurance coverage applied for, coverage under this receipt will not become effective. There will be no coverage under the receipt of premium and the amount paid will be returned to you.

Limitations on authority: No one but the president, the secretary or a vice president of UnitedHealthcare may change or waive the terms of this receipt of premium. No producer, financial services representative or medical examiner has authority to determine insurability or to make or modify any contract of insurance or waive any of our requirements.

I have read this receipt of premium, and reviewed my answers to all questions in the eligibility determination. I represent that the answers to all those questions are true and complete. I understand and agree that if the answers to any of the questions in the eligibility determination are not true and complete, the amount tendered will be returned and this receipt of premium will be null and void from the beginning. I understand and agree to all of the terms of this receipt of premium. I have received a copy of this receipt of premium.

SIGN HERE

Signature of applicant

Printed name of applicant

Date

No producer or financial services representative is authorized to accept any payment with the application if you answered "Yes" to (or left blank) any of the questions in the eligibility determination.

Receipt of \$ _____ is acknowledged from _____ in connection with the application for long-term care insurance on this date _____.

SIGN HERE

Signature of producer

UnitedHealthcare makes no representations as to the tax consequences of the premium paid under this receipt or the benefits you receive under this receipt. Consult your own legal or tax advisor.

Please make all checks payable to [United HealthCare Insurance Company]. Do not make a check payable to the producer or sales representative and do not leave the payee blank.

Applicant's copy

If question #5 in “Questions about Existing Coverage” on page 5 is answered “Yes,” complete this notice.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE (LTC) INSURANCE: **SAVE THIS NOTICE!** IT MAY BE IMPORTANT TO YOU IN THE FUTURE. According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance or long-term care insurance coverage and replace it with an individual long-term care insurance policy issued by UnitedHealthcare. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care insurance coverage is a wise decision.

STATEMENT TO APPLICANT BY PRODUCER: I have reviewed your current medical, health and LTC insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. The policy has no exclusion for pre-existing conditions. This means that health conditions which you may presently have are fully and immediately covered under the new policy, if such policy is issued.
2. In many states, state law provides that your replacement policy may not contain new pre-existing conditions or probationary periods. The policy you are applying for has no such pre-existing conditions or probationary periods.
3. Since you are planning to replace medical, health or LTC insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after you have thought about it, you still wish to terminate your present coverage and replace it with a new policy, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

SIGN HERE_____
Signature of applicant_____
Printed name of applicant_____
Date**SIGN HERE**_____
Signature of producer_____
Printed name of producer_____
Address_____
City, State, ZIP

The above “Notice to Applicant” was delivered to me on _____
Date

Producer's copy

If question #5 in “Questions about Existing Coverage” on page 5 is answered “Yes,” complete this notice.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE (LTC) INSURANCE: **SAVE THIS NOTICE!** IT MAY BE IMPORTANT TO YOU IN THE FUTURE. According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance or long-term care insurance coverage and replace it with an individual long-term care insurance policy issued by UnitedHealthcare. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care insurance coverage is a wise decision.

STATEMENT TO APPLICANT BY PRODUCER: I have reviewed your current medical, health and LTC insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. The policy has no exclusion for pre-existing conditions. This means that health conditions which you may presently have are fully and immediately covered under the new policy, if such policy is issued.
2. In many states, state law provides that your replacement policy may not contain new pre-existing conditions or probationary periods. The policy you are applying for has no such pre-existing conditions or probationary periods.
3. Since you are planning to replace medical, health or LTC insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after you have thought about it, you still wish to terminate your present coverage and replace it with a new policy, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

SIGN HERE_____
Signature of applicant_____
Date**SIGN HERE**_____
Signature of producer_____
Printed name of producer_____
Address_____
City, State, ZIP

The above “Notice to Applicant” was delivered to me on _____
Date

UnitedHealthcare Insurance Company
Home Office: [450 Columbus Boulevard, Hartford, CT 06115]

Administrative Office: [P.O. Box 541203, Waltham, MA 02453-1203, 800-555-5555]

Long Term Care Insurance
Potential Rate Increase Disclosure Form

1. Premium Rate: Premium rate that is applicable to You and that will be in effect until a request is made and approved for an increase, is on the application.

2. The premium for this policy will be shown on the schedule page of Your policy.

3. Rate Schedule Adjustments:

The premium rate will be effective the next billing date.

4. Potential Rate Revisions:

This policy is Guaranteed Renewable. This means that the rates for this coverage may be increased in the future. Your rates can NOT be increased due to Your increasing age or declining health, but Your rates may go up based on the experience of all policyholders with a policy similar to Yours.

If You receive a premium rate or premium rate schedule increase in the future, You will be notified of the new premium amount and You will be able to exercise at least one of the following options:

- (a) Pay the increased premium and continue Your coverage in force as is.
- (b) Reduce Your policy benefits to a level such that Your premiums will not increase. (Subject to state law minimum standards.)
- (c) Exercise Your nonforfeiture option, if purchased. (This option is available for purchase for an additional premium.)
- (d) Exercise Your contingent nonforfeiture rights. * (This option may be available if You do not purchase a separate nonforfeiture option.)

*** Contingent Nonforfeiture**

If the premium rate for Your Policy goes up in the future and You did not buy a nonforfeiture option, You may be eligible for contingent nonforfeiture. Here's how to tell if You are eligible:

- (a) You will keep some long-term care insurance coverage, if:
 - (1) Your premium after the increase exceeds Your original premium by the percentage shown (or more) in the table provided below; and
 - (2) You lapse (not pay more premiums) within 120 days of the increase.

- (b) The amount of coverage (i.e., new lifetime maximum benefit amount) You will keep will equal the total amount of premiums You have paid since Your Policy was first issued. If You have already received benefits under the Policy, so that the remaining maximum benefit amount is less than the total amount of premiums You have paid, the amount of coverage will be that remaining amount.
- (c) Except for this reduced lifetime maximum benefit amount, all other Policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.
- (d) Should You choose this Contingent Nonforfeiture option, Your Policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the Policy at age 65 and paid the \$1,000 annual premium for ten (10) years, so You have paid a total of \$10,000 in premium.
- In the eleventh year, You receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and You decide to lapse the Policy (not pay any more premiums).
- Your "paid-up" Policy benefits are \$10,000 (provided You have at least \$10,000 of benefits remaining under Your Policy.)

**Contingent Nonforfeiture Cumulative Premium Increase over
Initial Premium That Qualifies for Contingent Nonforfeiture Table**

Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.

Issue Age	Substantial Percent Over Initial Premium	Issue Age	Substantial Percent Over Initial Premium
29 and under	200%	72	36%
30-34	190%	73	34%
35-39	170%	74	32%
40-44	150%	75	30%
45-49	130%	76	28%
50-54	110%	77	26%
55-59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

UNITED HEALTHCARE INSURANCE COMPANY (UHIC)
Home Office: [450 Columbus Boulevard, Hartford, CT 06115]

Administrative Office: [P.O. Box 541203, Waltham, MA 02453-1203, 800-555-5555]

**Long Term Care Insurance
Personal Worksheet**

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Number(s) [LTC POL 1000]

The premium for the coverage you are considering will be \$_____ per month, or \$_____ per year.

Type of Policy: guaranteed renewable

The Company's Right to Increase Premiums: The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

Rate Increase History

The company has sold long-term care insurance since [2008] and has sold this policy since [2008]. The company has never raised its rates for any long-term care policy it has sold in this state or any other state.

Questions Related to Your Income

How will you pay each year's premium?

☐ From my Income ☐ From my Savings\Investments ☐ My Family will Pay

☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What is your annual income? (check one)

☐ Under \$10,000 ☐ \$10-20,000 ☐ \$20-30,000 ☐ \$30-50,000 ☐ Over \$50,000

How do you expect your income to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐ From my Income ☐ From my Savings\Investments ☐ My Family will Pay

The national average annual cost of care in [2007](year) was _____ (\$ amount), but this figure varies across the country. In ten years the national average annual cost would be about _____ (\$ amount) if costs increase 5% annually.

What elimination period are you considering? Number of days _____ Approximate cost \$_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

☐ From my Income ☐ From my Savings\Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

☐ Under \$20,000 ☐ \$20,000-\$30,000 ☐ \$30,000-\$50,000 ☐ Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

- | |
|--|
| <input type="checkbox"/> The answers to the questions above describe my financial situation.
or
<input type="checkbox"/> I choose not to complete this information.
(Check one.) |
|--|

- | |
|---|
| <input type="checkbox"/> I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. <u>I understand that the rates for this policy may increase in the future.</u> (This box must be checked). |
|---|

Signed: _____
(Applicant) (Date)

- ☐ I explained to the applicant the importance of completing this information.

Signed: _____
(Agent) (Date)

Agent's Printed Name: _____]

My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____
(Applicant) (Date)

The company may contact you to verify your answers.

Things You Should Know Before You Buy Long -Term Care Insurance

- Long-Term Care Insurance:** A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company has a limited right to increase future premiums.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
- Medicare:** Medicare does not pay for most long-term care.
- Medicaid:** Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you can keep your house, furniture, a living allowance and some joint assets. However, the government can put a lien on those assets.
- Your choice of long-term care services may be limited if you receive Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.
- Shopper's Guide:** Make sure the insurer or producer gives you a copy of a book by the National Association of Insurance Commissioners' called "Shopper's Guide to Long-Term Insurance." Read it carefully. If you decide to apply for long-term care insurance, and you are dissatisfied for any reason, you have the right to return the policy within 30 days. We will return any premium paid.
- Counseling:** Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

NOTICE

Your United HealthCare Insurance Company representative will be happy to help You with any question or problem relating to Your Policy. You can also contact Us with any question at:

1-877-272-3959

If You prefer, You can write to Us at the address shown below. Please include Your full name, address and policy number with all correspondence.

**Attn: Administrative Office
[P.O. Box 541203
Waltham, MA 02453-1203]**

If You feel that We have not fully handled Your request, You may call or write to the Arkansas Insurance Department.

**Attn: Consumer Service Division
1200 West Third Street
Little Rock, AR 72201-1904
1-800-852-5494**

Before You contact the Insurance Department, first contact United HealthCare Insurance Company and let Us assist You directly.

Your Agent (if applicable):

Name: _____

Phone: _____

Policy Disclosure Form

Important Information Regarding Your Policy's Long-Term Care Insurance Partnership Status

This disclosure notice is issued in conjunction with Your Long-Term Care Policy:

Some Long-Term Care insurance policies sold in Arkansas qualify for the Arkansas Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering Long-Term Care insurance coverage that meets certain State and Federal requirements. Long-Term Care insurance policies that qualify as Partnership Policies may be entitled to special treatment, and in particular an "Asset Disregard", under Arkansas's Medicaid program.

Asset Disregard means that an amount of the policyholder's assets equal to the amount of Long-Term Care insurance benefits received under a qualified Partnership Policy will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply. Asset Disregard is **not** available under a Long-Term Care insurance policy that is not a Partnership Policy. **The purchase of a Partnership Policy does not automatically qualify You for Medicaid.**

Partnership Policy Status. Your Long-Term Care Insurance Policy is intended to qualify as a Partnership Policy under the *Arkansas Long-Term Care Partnership Program* as of Your Policy's effective date.

What Could Disqualify Your Policy as a Partnership Policy. If You make any changes to Your Policy, such changes could affect whether Your Policy continues to be a Partnership Policy. ***Before You make any changes, You should consult with United HealthCare Insurance Company to determine the effect of a proposed change.*** In addition, if You move to a State that does not maintain a Partnership Program or does not recognize Your Policy as a Partnership Policy, You would not receive beneficial treatment of Your Policy under the Medicaid program of that State. The information contained in this Notice is based on current State and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of Your Policy under Arkansas's Medicaid program.

Additional Information. If You have questions regarding Your insurance Policy please contact United HealthCare Insurance Company. If You have questions regarding current laws governing Medicaid eligibility, You should contact the Arkansas Department of Human Services.

This form and all benefit statements received should be kept with Your Policy.

Solicitation Disclosure Form

Important Consumer Information Regarding the Arkansas Long-Term Care Insurance Partnership Program

Some Long-Term Care insurance policies sold in Arkansas may qualify for the Arkansas Long-Term Care Insurance Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their Long-Term Care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering Long-Term Care insurance coverage that meets certain State and Federal requirements. Long-Term Care insurance policies that qualify as Partnership Policies may protect the policyholder's assets through a feature known as "Asset Disregard" under Arkansas Medicaid program.

Asset Disregard means that an amount of the policyholder's assets equal to the amount of Long-Term Care insurance benefits received under a qualified Partnership Policy will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply. Asset Disregard is not available under a Long-Term Care insurance policy that is not a Partnership Policy. Therefore, you should consider whether Asset Disregard is important to you, and whether a Partnership Policy meets your needs. ***The purchase of a Partnership Policy does not automatically qualify you for Medicaid.***

What are the Requirements for a Partnership Policy. In order for a policy to qualify as a Partnership Policy, it must, among other requirements:

- Be issued to an individual after January 1, 2008;
- Cover an individual who was an Arkansas resident when coverage first becomes effective under the policy;
- Be a tax-qualified policy under Section 7702(B)(b) of the Internal Revenue Code of 1986;
- Meet stringent consumer protection standards; and,
- Must provide annual inflation protection for ages 75 and younger.

If you apply and are approved for Long-Term Care insurance coverage, United HealthCare Insurance Company will provide you with written documentation as to whether your policy qualifies as a Partnership Policy.

What Could Disqualify a Policy as a Partnership Policy. Certain types of changes to a Partnership Policy could affect whether such policy continues to be a Partnership Policy. If you purchase a Partnership Policy and later decide to make *any* changes, you should first consult with United HealthCare Insurance Company to determine the effect of a proposed change. In addition, if you move to a state that does not maintain a

Partnership Program or does not recognize your policy as a Partnership Policy, you would not receive beneficial treatment of your policy under the Medicaid program of that state. The information contained in this disclosure is based on current Arkansas and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy under Arkansas's Medicaid program.

Additional Information. If you have questions regarding Long-Term Care insurance policies please contact United HealthCare Insurance Company. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Arkansas Department of Human Services.

<i>SERFF Tracking Number:</i>	<i>UHLC-125942058</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>United HealthCare Insurance Company</i>	<i>State Tracking Number:</i>	<i>41087</i>
<i>Company Tracking Number:</i>	<i>LTC POL 1000 AR</i>		
<i>TOI:</i>	<i>LTC03I Individual Long Term Care</i>	<i>Sub-TOI:</i>	<i>LTC03I.001 Qualified</i>
<i>Product Name:</i>	<i>INDIVIDUAL LONG TERM CARE</i>		
<i>Project Name/Number:</i>	<i>LTC/LTC POL 1000 AR</i>		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: UHLC-125942058 State: Arkansas
Filing Company: United HealthCare Insurance Company State Tracking Number: 41087
Company Tracking Number: LTC POL 1000 AR
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: INDIVIDUAL LONG TERM CARE
Project Name/Number: LTC/LTC POL 1000 AR

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 12/11/2008

Comments:

SEE ATTACHED CERTIFICATION OF READABILITY.

Also, the Consumer Information Notice is included under the Forms schedule.

Attachment:

AR Certification of Readability.pdf

Review Status:

Satisfied -Name: Application 12/11/2008

Comments:

Applications are included under Form Schedule tab.

Review Status:

Satisfied -Name: Outline of Coverage 12/11/2008

Comments:

Outline of Coverage is attached under Form Schedule tab.

Review Status:

Satisfied -Name: PARTNERSHIP CERTIFICATION 12/12/2008

Comments:

SEE ATTACHED PARTNERSHIP CERTIFICATION.

Attachment:

Partnership Certification.pdf

Certification of Readability

This is to certify that the form listed below is in compliance with recommended insurance policy readability law.

Form LTC POL 1000 AR is to be issued by United Healthcare Insurance Company.

1. The document is printed in not less than ten (10) point type, one (1) point leaded.
2. The layout and spacing of the document separate the paragraphs from each other and from the border of the paper.
3. The section titles are captioned in bold face or otherwise stand out significantly from the text.
4. The document does not use unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions.
5. The style, arrangement and overall appearance of the policy gives no undue prominence to any portion or to any endorsements or riders.
6. A table of contents is included in the policy form.
7. A minimum flesch score of 40.



Signature of Company Officer

— VICE-PRESIDENT, COMPLIANCE

Title

December 12, 2008

Date

APPENDIX C
ISSUER CERTIFICATION FORM
(relating to Qualified State Long-Term Care Insurance Partnership)

In order to provide the Insurance Commissioner with information necessary to provide a certification for policies, this Issuer Certification Form requires information and a certification from issuers of long-term care insurance policies with respect to policy forms that may be covered under the Qualified Partnership of the State.

An insurance company may request certification of policies from time to time and, accordingly, may supplement this issuer certification form, *e.g.*, as it introduces new long-term care insurance policy forms for issuance.

I. GENERAL INFORMATION

A. Name, address and telephone number of issuer:

United HealthCare Insurance Company
450 Columbus Boulevard
Hartford, CT 06115

B. Name, address, telephone number, and email address (if available) of an employee of issuer who will be the contact person for information relating to this form:

Karyn A. Feeney, Director, Contract & Compliance
P.O. BOX 130, MONTGOMERYVILLE, PA. 18936
(267) 470-1537, karyn_a_feeney@uhc.com

C. Policy form number(s) (or other identifying information, such as certificate series) for policies covered by this Issuer Certification Form (expand the space below as required):

LTC POL 1000 AR

Specimen copies of each of the above policy forms, including any riders and endorsements, shall be provided upon request.

II. CERTIFICATIONS

- A.** I hereby certify that the policy forms listed above are in compliance with Rule 13 and Rule 94 and all other Arkansas statutes and rules regarding long-term care insurance.
- B.** I hereby certify to the best of my knowledge and belief that all producers who sell, solicit or negotiate long-term care insurance products on {insert issuer name's} behalf have received the training required for Partnership policies and that they demonstrate an understanding of the policies and their relationship to public and private long-term care coverage.
- C.** I hereby certify that the answers, accompanying documents, and other information set forth herein are, to the best of my knowledge and belief, true, correct, and complete.

12/12/08

Date

PAUL KALLMEYER, VICE-PRESIDENT, COMPLIANCE

Name and title of officer of the Issuer

Signature of officer of the Issuer